



Containment? An investigation into psychoanalytic
containment and whether it is provided by staff in an
NHS institution in relation to someone with a diagnosis
of personality disorder.

Submitted by Elizabeth Caroline Weightman
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First Supervisor: Dr Janet Smithson
Second Supervisor: Dr Nicholas Sarra

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confidentiality.

Signed.....

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ABSTRACT

This research investigated the psychoanalytic idea of containment in the context of NHS staff responses to a person diagnosed with personality disorder. The aim was to identify what, if any, containment was provided by staff for someone diagnosed with personality disorder by recording staff responses to an assessment and analysing the discourse. The research was undertaken with participants selected to represent a cross section of staff in the organisation and included senior and junior, clinical, administrative and managerial staff.

The discourse analysis of the interviews examined defences against containment such as splitting, projective identification and idealisation and the positions people occupied in relation to the material and the researcher, as well as looking for examples of containment. Reflexivity was a key part of the methodology, forms a significant part of the thesis and is used to contribute to the discussion. Reflexivity, findings from the review of the literature and the analysis of the interviews form the basis of the discussion and conclusions.

The research showed that containment, in its psychoanalytic sense, is often avoided and defended against. Key difficulties with developing the capacity for containment were found to be: conflict between the personal and professional in staff and anxiety in relation to the power of others in the organisation. Suggestions are made for how changes could be made within the organisation and how this could benefit both staff and people who use services. Changing the approach to containment could save costs as some repeat admissions could be avoided and staff satisfaction enhanced.

The conclusions from the research make a contribution to clinical practice in NHS settings, to the psychoanalytic theory of containment and to the methodology of psychoanalytic discourse analysis. Recommendations for further research include more psychoanalytic discourse analysis to identify defences in text and research evaluating reflective staff groups.

Key words: Personality disorder, containment, staff, psychoanalytic discourse analysis, reflexivity.

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ABBREVIATIONS

CASP – Critical Appraisal Skills Programme

CERQual – Confidence in the Evidence from Reviews of Qualitative Research

DPT – Devon Partnership Trust

DSM – Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association

EPHPP – Effective Public Health Practice Project

ICD - International Statistical Classification of Diseases and Related Health Problems maintained by the World Health Organization

NHS – National Health Service

PEPweb – Psychoanalytic Electronic Publishing Database

RIO – National Health Service data operating system

UK – United Kingdom

USA – United States of America

WHO – World Health Organization

“Especially today, when facing pain has become increasingly difficult; pain is either repressed or exploded into violence and massacre. Representation depends on a more intimate experience of pain, an intimacy that is currently in need of renewal”

(Kristeva, 2002, p.133).

1

Introduction and Background

1.1 Introducing the Research Problem

In this thesis I explore the psychoanalytic concept of containment and investigate whether staff in an NHS institution provide any such containment for people diagnosed with personality disorder. I approach the investigation by interviewing staff in a way which allows them to respond freely to the assessment of a person diagnosed with personality disorder. The key question is: what psychoanalytic containment is provided by staff in an NHS Trust for people diagnosed with personality disorder?

In this chapter I will define personality disorder, describe the setting for the research and outline the psychoanalytic concept of containment. I will show how the idea of containment has developed and identify some of the criticisms of the concept. One section discusses the use of the psychoanalytic idea of containment in studies of organisations. Finally, the research questions will be described.

Consideration of containment is particularly significant for the treatment of people diagnosed with personality disorder because of the high level of risk of self-harm and suicide. The NHS Trust where this research was carried out has adopted a recovery model with a culture of care, treatment and recovery. This means that the risk of

suicide and severe self-harm in people diagnosed with personality disorder challenges the approach of the organisation in that suicide can be seen as a failure. The threat of death is not just to the suicidal person but can also be to the ethos and survival of the institution and staff themselves.

Containment, as defined for the purposes of this thesis (see Section 1.8, page 32), is a common term in much of post Bion psychoanalytic theory. The concept can be considered as similar, but not identical, to other psychoanalytic concepts from different schools. For example: Winnicottian ideas of holding (Winnicott, 1965), ideas of agency in mentalization theory (Fonagy, Gergely, Jurist and Target, 2004 and Abel-Hirsch, 2016) and ideas of secure attachment in attachment theory (Bowlby, 1973). This thesis therefore has a broad application across all these fields. The concept of containment in psychoanalysis differs from the use of the term containment to describe physical containment, which is common in the language of mental health organisations.

This thesis investigates psychoanalytic containment for people with a diagnosis of personality disorder. It shows how staff respond to the assessment of a person diagnosed with personality disorder; how they respond to self-harm and ideas of suicide and how they defend against and avoid psychoanalytic containment.

The aim was to explore what evidence there is of psychoanalytic containment and what form this takes. The research investigates what, in terms of the psychoanalytic idea of containment, staff may defend against or be blind to and develops an idea of psychoanalytic containment which could be used in the training and practice of staff

within the organisation. It investigates the nature of psychoanalytic containment in several senses, the capacity to reflect on and bear deadly and aggressive feelings, attunement and orientation and representation. Countertransference is used as the basis for reflexive practice throughout the research.

In a previous unpublished study (Weightman, 2013) the findings were that: service users identified being able to think about feelings; developing a sense of awareness of their own responsibility and a sense of an acceptance of limitations as key positive aspects of their experience. These ideas form part of the psychoanalytic concept of containment. This was a preliminary project, which was part of the Doctorate in Clinical Practice course, and contributed to the development of this research. This research investigates the concept of containment further and identifies ways in which the culture of a health trust in terms of staff responses may or may not contribute to such containment. It is also an aim of the research to influence the use of the institutional concept of recovery and to develop an alternative, which would take account of containment as an aim and an achievement.

1.2 Defining Personality Disorder

Personality disorder is defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) as follows:

Personality disorders are associated with ways of thinking and feeling about oneself and others that significantly and adversely affect how an individual functions in many aspects of life. They fall within 10 distinct types: paranoid

personality disorder, schizoid personality disorder, schizotypal personality disorder, antisocial personality disorder, borderline personality disorder, histrionic personality, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder and obsessive-compulsive personality disorder. (American Psychiatric Publishing, DSM-5, 2013, p. 1)

Particularly with the emotionally unstable type of personality disorder there is a tendency towards suicide and self-harming (World Health Organization, (WHO), 2016). These risk events can be described as the result of emotions, which are uncontained in the psychoanalytic sense.

The WHO (1993) states that the diagnosis of personality disorder for research purposes involves: "Evidence that the individual's characteristics and enduring patterns of inner experience and behavior deviate markedly as a whole from the culturally expected and accepted range (or 'norm')" (WHO, 1993, section F.60). The WHO continues by saying that such deviation needs to be evident in one or more of the following: cognition, affectivity, control over impulses or relating to others.

1.3 Setting for the Research

The setting of the research is an NHS unit dedicated to treating people with a diagnosis of personality disorder. The unit does not specify the particular type of personality disorder diagnosis needed for treatment but the majority of people referred have a diagnosis of emotionally unstable personality disorder. This category, found in ICD-10, is the diagnostic name for the category of borderline personality disorder in DSM-5.

The unit is part of the Specialist Services of Devon Partnership NHS Trust (DPT). A diagnostic tool is used as a preliminary screening for those referred to the service, the Thames Valley Severity Index (Appendix A). Potential users of the unit's service must have a severity score of eight or above. This means that many referrals are of people at a high risk of suicide and one potential participant identified for this research committed suicide after their assessment and referral to the unit. This event had a significant impact on the research and is discussed in Chapter 6: Reflexivity. The unit is psychoanalytically based in its approach to treatment and the issue of what constitutes containment and how this can be developed is important for the future of the service. The psychoanalytic approach of the unit has been adapted, in response to a redefinition of personality disorder as a relational affective disorder by Mizen (2014). The approach to treatment in the unit is described by Mizen (2014) as originating from psychoanalytic and neuroscientific understandings and focusing on affect, projection and introjection as processes, claustrophobic and agoraphobic states, regression and defences, which result in a failure of symbolisation.

The therapeutic provision of the unit bears many similarities to the programme at the Cassel Hospital, London, particularly in terms of the psychoanalytic orientation and the structure of the programme. However, there are differences. The unit from which the assessment is selected for the purpose of this research is based on the approach identified by Mizen (2014) and the programmes run by the unit are all non-residential. There is an intensive programme of seven months' duration, which is four days a week, and a step down and community based combined programme of group, individual work and psychosocial practice of two and a half or three years'

duration. The unit is part of the provision of Devon Partnership NHS Trust (DPT) and has, since 2011, been funded as a specialist unit. There is current research within the unit, which is identifying outcomes of the programme and investigating service user reflections but no research focusing on psychoanalytic containment by the staff or institution as a whole.

I am an adult psychoanalytic psychotherapist within the unit and have professional lead responsibility for psychotherapy, together with a co-professional lead. Both professional leads are responsible clinically to the medical consultant psychiatrist in psychotherapy. There are ethnographic implications of my position as researcher in this research and these are acknowledged as part of the reflexivity, data analysis and conclusions. My position as researcher is described in Chapter 3: Methodology (Section 3.1.6 and 3.1.8).

1.4 Theoretical Background to the Psychoanalytic Concept of Containment

In The Shorter Oxford English Dictionary (1983) containment is described as: “The action or fact of holding or holding together”. In healthcare and in society in general this concept has often been used in terms of physical holding. Examples are mental health inpatient wards or prisons. For instance, Bowers, Alexander, Simpson, Ryan and Carr-Walker (2007), compare containment measures in mental health wards across Europe, all of which are physical. Containment in an emotional or psychological sense is less frequently used in mental health and has been associated with an avoidance of emotion or shutting down of feelings.

The psychoanalytic use of the term containment emerged from Klein's original description of projective identification, as described in the following section of this chapter (Klein, 1946). She linked this to Freud's writing about the reality principle and to the ideas of Fairburn and Winnicott (Klein, 1946, pp.99-100). Klein described how one of the schizoid early defences was a process of splitting off parts of the self and projecting them into others or objects. Her theory was that repeating cycles of projections and introjections was a developmental process of the ego.

Bion (1959) wrote about the potential function of a mother to receive and process the projections of the infant. He stated that if the analyst or mother was unresponsive, "The result is excessive projective identification by the patient and a deterioration of his mental process" (Bion, 1959, p. 312). In *Learning from Experience* (1962a) Bion used the term *reverie* to describe the mother's state of mind when she is able to take in and process projections. He wrote: "I shall abstract for use as a model the idea of a container into which an object is projected" (Bion, 1962a, p.90). For Bion this process involved a move from beta to alpha functioning and was a process which changed emotional experience into cognitive activity and a process of thinking (Bion, 1962a). For him this psychic change involved disturbing existing ways of dealing with raw emotions, connecting with the emotion and then re-structuring the way of processing the feelings into thoughts. Locating this process in Kleinian theory, he thought that the move was from a fragmented paranoid schizoid state to a depressive position, which was the development of new conjunctions or structures. Bion thought that this process of change was potentially catastrophic and that the development of new conjunctions meant having a capacity to bear and contain the paranoid schizoid fears, previously projected, of annihilation and death.

An aspect of psychoanalytic containment that differentiates it from a dictionary definition is that in psychoanalysis the term refers to a communicative mental process, albeit one that can be internalised when learnt from experience.

1.4.1 Containment and Projective Identification.

When first introduced by Bion (1958b) the term container was used in relation to Klein's concept of projective identification. In his paper, *On Hallucination*, Bion describes how his patient had been hostile and was afraid that he would murder his analyst, Bion. The session ended at the point that this was expressed. Bion linked this experience to Klein's description of a mechanism which, "Produces problems for the patient by engendering fear of the analyst who now is a container of a bad part of himself" (Bion, 1958b, p.342).

The mechanism alluded to by Bion was projective identification. Although Klein was not the first person to use this term (Spillius, 2012) she had mentioned it in her paper, *Notes on Some Schizoid Mechanisms* (1946). In this paper Klein described the process of projective identification.

Together with these harmful excrements, expelled in hatred, split off parts of the ego are also projected on to the mother or, as I would rather call it, into the mother. These excrements and bad parts of the self are meant not only to injure the object but also to control it and take possession of it. Insofar as the mother comes to contain the bad parts of the self, she is not felt to be a separate individual but is felt to be the bad self.

(Klein, 1946, p.102)

Klein describes, in her following paragraph, the parts of the self that were projected as both good and bad. In a later version of this paper (Klein, 1952) the term projective identification, as a defining term, was added to the description.

This process was openly acknowledged by Bion (1962a) as being one where the mother is the recipient of feelings that the infant is unable to contain and that a process, which he names as a modification of feelings or later, containment, takes place, which then enables the infant to tolerate and contain them.

Melanie Klein has described an aspect of projective identification concerned with the modification of infantile fears; the infant projects a part of its psyche, namely its bad feelings, into a good breast. Thence in due course they are removed and re-introjected. During their sojourn in the good breast they are felt to have been modified in such a way that the object that is re-introjected has become tolerable to the infant's psyche.

(Bion, 1962a, p. 90)

1.4.2 Containment: Paranoid schizoid to depressive position.

By linking the ideas of container-contained and containment with projective identification Bion (1958b) also linked the concept of containment to Klein's concepts of the paranoid schizoid and depressive positions. Klein's idea of these positions was dynamic, there were shifts from position to position that occurred throughout life. Bion wrote in *Attention and Interpretation* (1970, p.123) that the configuration of container and contained was derived from Klein's description of the paranoid schizoid and depressive positions. For Bion (1954) the capacity to form symbols and

thereby to verbalise thoughts and feelings depended on the ability to grasp whole objects. The process was an abandonment of the paranoid schizoid position with its attendant splitting and an emergence of the depressive position. The process of containment of projected feelings was key to this shift to symbolism, thinking, verbalisation and active integration.

1.4.3 Containment: Reverie, Alpha Function and Symbolisation.

Maternal reverie was a term used by Bion (1962a) to describe the mother's state of mind when she can take in the child's projected fear as reverie. He linked this capacity to the link that mother had with father. This, process, it is clear, did not just apply literally to mothers and fathers but to others who could function in this way.

The process of containment was further described by Bion as alpha functioning, by which unprocessed beta elements were modified (Bion, 1962a). Bion also linked the idea of containment or container/contained to the early development of the process of thinking (Bion, 1962b) and to the idea of curiosity (Bion, 1958a).

In *Learning from Experience* (Bion, 1962a) links dreaming to the alpha-function process. He states (Bion, 1962a, p. 6) that as far as alpha functioning is successful dream thoughts are produced. He likens hallucination rather than dreaming to beta elements that are used in projective identification. Ogden (2003) writing on this theme quotes Bion,

It used once to be said that a man had a nightmare because he had indigestion and that is why he woke up in a panic. My version is: The sleeping

patient is panicked; because he cannot have a nightmare, he cannot wake up or go to sleep; he has had mental indigestion ever since.

(Bion, 1962a, p.8)

1.4.4 Containment and Nameless Dread.

A particular aspect of Bion's idea of containment concerning death also holds significance for the topic of this research. Bion (1962b) identified that normal development would include the projection of the fear of dying into the mother who, by the process of containing, would enable the idea to be tolerable to the infant mind. He wrote (Bion, 1962b, pp.308-309) that if this process fails the idea of dying is stripped of meaning for the infant and is reintrojected as a nameless dread.

The key implications of Bion's theory of containment are that it concerns feelings that are unable to be thought about. If these feelings are projected or enacted they, according to Bion's theory, need to be subject to a process of containment or modification. In early emotional development this function needs to be undertaken by another.

1.5 Development of the Psychoanalytic Concept of Containment

O'Shaugnessey's paper, *Whose Bion?* (2011) stresses how influential Bion's work has been and how it has been taken up by psychoanalysts of different orientations but also how differently it has been interpreted (Ogden, 1982, Ferro, 1999, Eigen 1998, Symington & Symington, 1996). She attributes the popularity to a kind of coherence in Bion's writing that is to do with his constant: "Concern with the

instinct to know” (O, Shaugnessey, 2011, p.33). Her reflections are concerned with the whole of Bion’s thinking and particularly the way his earlier writings have been more emphasised by Kleinian thinkers and his later writings by the others to whom she refers. She thinks that psychoanalysis is too young to have identified a universal language, even though this was a hope of Bion’s: “The abstractions intended to be elements of psycho-analysis should be capable of combination to represent all psycho-analytical situations and all psycho-analytical theories” (Bion, 1963, p.5). Bion made an attempt to do this with his grid (Bion, 1963). A copy of Bion’s grid is to be found in Appendix B. This grid was to be used to evaluate the transformations that Bion described in his book of the same name (Transformations, Bion, 1965). As can be seen from the quotation below, some of the components of the process modelled in the grid were taken from Bion’s earlier description of containment. All seven of the categories of theory given below relate to containment in the sense that they are theories of primitive functions, which need another mind or internalised process to transform or contain them. The theories Bion used for the category E which is named, “Conception”, in the grid were:

- 1) The theory of projective identification and splitting; mechanisms by which the breast provides what the patient later takes over as his own apparatus for alpha-function.
- 2) The theory that some personalities cannot tolerate frustration.
- 3) The theory that a personality with a powerful endowment of envy tends to denude its objects by both stripping and exhaustion.
- 4) The theory that at an early stage (or on a primitive level of mind) the oedipal situation is represented by part objects.

- 5) The Kleinian theory of envy and greed.
- 6) The theory that primitive thought springs from experience of a non-existent object, or, in other terms, of the *place* where the object is expected to be, but is not.
- 7) The theory of violence in primitive functions.

(Bion, 1965, p. 51)

As Vermote (2011) points out: Bion's approach changed psychoanalysis from a focus on interpretations to a focus on the process of transformation, transformation was now a concept which included the earlier idea of containment. The grid was a step in this articulation of process but Bion himself relinquished it in his later writings (Bion, 1970).

The concept of containment in itself has also been the subject of various interpretations and has become an important concept for most Kleinian and other analysts. Segal (1975) wrote, "The containment of anxiety by an external object capable of understanding is a beginning of mental stability" (Segal, 1975, pp. 134-5).

Fisher (2011) suggests that containing is a developmental dynamic and an expression of what Bion named a K state of mind. K meaning, in Bion's context, the epistemophilic instinct referred to by Freud and Klein. In Bion's terms if K was overridden by L (Love) or H (Hate) there would be no process of containment.

Ogden (2004) differentiates Bion's idea of containment and container/contained from Winnicott's idea of holding. He defines Winnicott's idea of holding as a mother or

analyst's role in protecting the continuity of the child or person's experience of being and becoming over time. In Winnicott's terms this is a sensation based feeling state of being held in the arms of the mother. It is perhaps closer to a definition of what is commonly described as physical containment but it perhaps minimises Bion's view of a mental process that involves a lived dynamic emotional experience.

Cartwright (2010) conceptualises containment, with the invariant of K, as having three different levels of psychic experience. He divides these levels into: non-symbolic, preverbal and symbolic.

Ceglie (2013) links Bion's ideas of container-contained to the Greek idea of a symbolon. She uses the term orientation to describe the kind of attunement necessary to enable containment to take place. Although different terminology this idea links the theory of containment to the theories of Winnicott (1955); Fonagy and Target (1997); Hobson (2002); Stern (1985) and a more experimental area of psychoanalytic studies which includes attachment theory. Mentalization, as described by Fonagy, Gergely, Jurist and Target (2004, p. 436), presumes a self-reflectivity and a sense of agency, which is containing.

There is some theoretical tension, as well as a potential difference of emphasis clinically, between Bion's ideas of the necessary disturbance of previously employed projective mechanisms prior to re-structuring, contact with the emotion and the new conjunctions of containment and the depressive position and the ideas that Ceglie (2013) refers to of attunement and reciprocal orientation. Bion (1970, p.124) refers to an oscillation between patience and security with patience being a state of mind,

which tolerates frustration and suffering. A possible theory is that containment has three parts: orientation, disturbance and then a new pattern, which involves representation or symbolisation.

Dynamic systems theory (Thelen and Smith, 1995) has some similarities with Bion's ideas. This theory has been used by cognitive psychologists, neuroscientists and psychoanalysts (Schore, 1999) to investigate psychic change. Psychic change is described as patterns that settle, are disturbed and then settle again into a new pattern (Hayes, Laurenceau, Feldman, Strauss and Cardaciotto, 2007). Tronick and Beeghly (2011) identify open dynamic systems as the infant mental state that is the basis of meaning making. Hayes et al., (2007) state that change in psychotherapy is positively related to disturbance during the course of the therapy. Cartwright (2010, p.11-15) refers to field theory as permitting a dynamic systems view of the encounter between two minds. This would fit with Bion's approach, which underlines the importance of disturbance in containment, although systems theory is not focused on the processing of emotion as being the essential component of the disturbance and change.

The idea of containment has been extended and clarified within psychoanalysis and some other disciplines, such as systems theory, have developed ideas which could also be said to relate to the idea of containment. All the writers summarised above have contributed from the perspective of psychotherapy or psychoanalysis. There has been a further development of the psychoanalytic concept of containment in respect of organisations and, as this research is focusing on containment by staff in an organisation, information about these developments is given in the next section.

1.6 Psychoanalytic Containment in Organisations

Hinshelwood (2001) uses case material of a patient who took an overdose to consider the need for a containing relationship with the institution in order to promote the internalisation of a psychoanalytic concept of containment. In this case the organisation had moved the time of a meeting due to poor attendance. The patient had been one of the poor attenders. The fact that the organisation shifted the time meant that this patient lost any sense that the organisation could think. His action (non-attendance) shifted the organisation as if the organisation was unable to bear the non-attendance or unbearable feeling associated with that. The process of containment did not happen. The patient took an overdose.

In extending the psychoanalytic idea of containment beyond the consulting room to organisations Nutkevitch (2001) wrote that: "Containing can be regarded as the ability of an individual or a human system to keep inside and 'own' parts of themselves which there is an urge to get rid of - to evacuate them via projective identification" (p.270). Nutkevitch (2001) also notes that limit setting is an act of containment. This is in line with Bion's ideas of containment reflecting the essence of the depressive position. The ideas are of limit and reality as opposed to the omnipotence and splitting of the paranoid schizoid position.

Setting of limits in psychodynamic work and the implications of containing aggression and impulsivity are considered by Henry (2010). Limitations are an aspect of containment. Kernberg (2012), in his description of Transference-Focused

Psychotherapy, states that the crucial elements of the structure of treatment for people with borderline personality disorder are limit setting and interpretation of the transference.

In a study published in 1960 Menzies observed defensive manoeuvres amongst staff in a hospital including: splitting of the nurse patient relationship; a denial of individual responsibility and depersonalisation. The research was conducted by formal interviews of 70 nurses and then, in addition, by discussions with groups of staff and observations. This report did investigate staff and their defence mechanisms but did not link this to a detailed patient case or to the concept of containment as a purposeful endeavour for patient care.

Main (1990) states that staff at the Cassel Hospital were found to be acting in ways that were contrary to the psychoanalytically based aim of treatment to promote integration. He does not however give evidence of the research on which this conclusion was based. In his paper *The Ailment* (Main, 1989) he describes research into staff difficulties in containing and bearing particular patients and indicates the need for further research.

Ramsay (2002) investigated by observational study the emotional demands of working with the dying amongst hospice staff and found that staff were prompted to shut off difficult and painful feelings. This study was limited in scope but took a psychoanalytic approach. Morris (2000) described an observational study of staff – patient relations in a medical ward and a mental health hostel. The method relies on the method of infant observation as introduced into psychoanalytic training (Bick,

1964). Morris (2000) found that the unbearability of structures set up to contain the severely mentally ill arose from the unbearability of the mental illness rather than from the structures themselves. In other words, emotional containment was the problem. Edwards (2000) in an observational study of a long-stay psychiatric ward found that her sense of time and place as a researcher was disorientated and she had little thinking space for reflection herself. This again describes a difficulty of containment of the emotional experience of disturbance.

Using psychoanalytic thinking to understand what may be happening when an organisation functions less well than it could has been written about by Allcorn (2008). He uses the concept of a narcissistic organisation and Ronningstam's typology of pathological narcissism, arrogant, shy and psychopathic (Ronningstam, 2005), to analyse institutional culture. In this way the organisation is treated like a psychoanalytic patient. The question is raised though by Allcorn (2008) as to whether consultation to an organisation resulting from such a study can be creative without creating chaos. This is a relevant question about the use of the conclusions of this research as discussed in Chapters 7 and 8 of this thesis.

1.7 Criticisms of the Concept of Containment

There is criticism of the term containment from the relational school quoted by Apfelbaum (2005) from Mitchell (1997), who states that Bion's idea of containment: "Poses all the same problems as the classical ideal of neutrality but here a squeaky-clean container substitutes for the neutral, blank screen" (Mitchell, 1997, p. 189). However, this criticism seems to imply a non-emotional definition of containment,

which would not correspond to the disturbance recognised by Bion or to the use of countertransference responses to projective identification.

The common understanding of containment as physical holding and something concrete or solid, is, as pointed out at the beginning of this thesis (Section 1.1), a disadvantage with the use of the term. The psychoanalytic concept as described in this section and in Figure 1 (page 34) is specifically a process, dynamic and relational process.

1.8 Summary of Background and Introduction

In this chapter I have defined personality disorder, described the setting for this research and outlined the psychoanalytic concept of containment. I have shown how the idea of containment has developed including the way in which it has been applied to the study of organisations and identified some of the criticisms of the concept.

I have described how the psychoanalytic concept of containment significantly differs from other physical definitions in that it is psychological in the sense of being to do with affect, is dynamic and requires a reception and processing of the split off feeling by another person or by an internalised representation of that object which allows for an internal process to take place.

The process of containment has been described as utilising projective identification as part of primitive paranoid schizoid defences such as splitting. The projection,

which needs containment, has also been described as a communication of the fear of death or nameless dread. The potential for containment is in the containing reflection of another mind or internal representation of that which can process and manage these feelings.




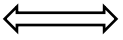
Caper summarises it: “Analytic containment converts a state of mind that is unbearable (because it destroys one’s capacity to think, perceive and phantasize) into a state of mind that is merely insecure” (Caper, 1999, p.155). This, he says, corresponds to Freud’s idea that psychoanalysis was about converting hysterical misery into common unhappiness (Freud, 1893).

As described in Sections 1.5 and 1.6 of this chapter the concept of containment has been taken up by people from various schools of psychoanalysis, including neuropsychanalysis, and within a variety of contexts outside the consulting room, including organisational contexts. Similar concepts have appeared in other disciplines, such as systems theory (see Section 1.5). It seems to be the case that, as O’Shaughnessy (2011) suggests, there is a plurality of approaches to Bion’s original idea and not yet a clearly defined concept.

Figure 1 (page 34) shows a simplified diagram of the process of psychoanalytic containment as described in this chapter.

Figure 1: The process of containment in a diagrammatic view

NB Persons 2 and 3+ can also be understood as internal representations or internal objects

Person - 1	Process	Person – 2 & 3+
i) Expression via action or projection, security (certainty)	 1 to 2 and 3+ Communication	Orientation to felt impact
ii) Cessation, repetition or continuation	 1 to 2 and 3+ Realisation of disturbance	Disturbance – experience of paranoid schizoid feeling (needs support of 3 external or internal to become conscious or thought about)
iii) Acceptance of verbal representation – depressive position	3+ to 2 to 1 Communication 	Representation of feeling and disturbance – can be verbal
iv) Limitation – boundary, loss of omnipotence or narcissistic state, uncertainty	1,2 & 3+ Settling,  suffering, patience,	Depressive position experience
Repeat- learning from the experience?		

There are three main areas for investigation that emerge from this introduction.

The first is theoretical. This research searches for knowledge of the concept of containment in terms of a process that can be seen in language and through my own reflexivity, not just in the consulting room, but in the wider context of an NHS Trust.

The second is clinical. If, as is suggested in this introduction and background, containment as psychoanalytically defined is lacking in people diagnosed with personality disorder then investigating the capacity for containment in staff throughout the institution may have implications for the treatment of this patient group.

The third is organisational. The research poses questions about whether psychoanalytic containment is offered by the staff of an NHS institution in relation to a person diagnosed with personality disorder and, following the analysis, suggestions are made about how containment could be improved.

1.9 Research Questions

1.91 Overall Aim

To investigate psychoanalytic containment, how it is provided by staff in an NHS Trust for people diagnosed with personality disorder and how it may be developed both as a concept and as a capacity of the institution.

1.9.2 Research Questions

1. What psychoanalytic containment do staff of the institution provide for someone diagnosed with personality disorder?
 - a) How do staff talk about themselves in relation to the assessment of a person with a diagnosis of personality disorder?
 - b) How do staff talk about self-harm, suicide, annihilation and death in this setting?
 - c) How are psychoanalytically defined defences employed to avoid and defend against the psychoanalytic idea of containment?
2. How does reflexivity in the research process develop the idea of containment?
3. What are possible future developments for the organisation in terms of improving containment?

2

Literature Review

2.1 Background

This chapter describes the background, aims, method, results and conclusions of a review of the literature carried out to explore existing research into the containment, as psychoanalytically defined, of people with personality disorder in mental health services. The search was broadened to include quantitative and qualitative research as well as psychoanalytic papers.

It is estimated that the prevalence rate for any type of personality disorder is at least 10% of the general population in the USA and Europe (Sansone and Sansone, 2011, Torgerson, 2014). There is a high incidence of personality disorder amongst prisoners and in psychiatric inpatient units. (NICE guidelines, 2009). The term personality disorder includes all the sub categories defined in DSM-5. There is no single particular treatment recommended in NICE guidelines for borderline personality disorder, although many different psychotherapeutic and pharmaceutical approaches have been attempted (NICE guidelines, 2009, p.378-392). The guidelines state the need for further research.

Staff in mental health services and elsewhere have found people with personality disorder hard to tolerate and assist (Skodol, Bender and Oldham, 2014). Problems in staff teams working with people with personality disorder are well documented (Deans and Meocevic, 2006, James and Cowman, 2007 & Markham and Trower,

2003). This has resulted in many people being sent long distances to intensive care units. A report from the Care Quality Commission on Devon Partnership Trust (Care Quality Commission, 2016) states:

Some patients were provided with the care that they needed far away from their local ties and there was a risk that families may find it hard to visit people who were at their most unwell which was a challenge to the recovery process

(Care Quality Commission, 2016, p.23).

The elements of personality disorder that make for difficulties with staff are concerned with the high level of risk of suicide, self-harming, eating disorders and substance misuse. Staff and managers working with this group have to be able to bear the high levels of disturbance associated with these states without resorting to dismissal or revenge (Sansone and Sansone, 2014, p.459).

As outlined in the introductory chapter psychoanalytic ideas of containment have developed from an origin in the work of Bion (1958b). The concept is of a level of dynamic containment of raw emotion, which in psychoanalytic terms would be described as being able to bear and process unprocessed projections as portrayed in diagrammatic form in Figure 1. It is important to note for the purposes of this literature review that containment is descriptive of an internal process or a process between two or more people and is not about physical holding (see Section 1.4).

2.1.1 Aims

This systematic literature review aims to identify recent (1998 – 2016) research and psychoanalytic writing about staff and institutional attitudes to people diagnosed with personality disorder and in addition to explore to what extent the psychoanalytic concept of containment applied to this context has been investigated.

Using the term ‘staff attitudes in mental health’ to elicit research relevant to the psychoanalytic concept of containment and broadening the search from qualitative to quantitative research proved to be the only way of investigating research in the field. Preliminary searches of social science databases limited to psychoanalytic containment, staff, organisations, personality disorder and qualitative work gave no results. The database that gave a number of papers relevant to the psychoanalytic concept of containment was PEPweb (Psychoanalytic Electronic Publishing). These papers, not research in the qualitative or quantitative social science models, are included in the review under the heading of expert papers.

Following the review of existing research areas for further research are identified giving a rationale for the current study.

2.1.2 Definition of Research for the Purposes of the Literature Review

Research is any, “Inquiry which is carried out, at least to some degree, by a systematic method with the purpose of eliciting some new facts, concepts, or ideas” (Peritz, 1980, p. 251). This definition was utilised by Turcios, Kumar Agarwal, and Watkins (2014, p.474) as one that, although criticised as broad,

had nevertheless been found to give consistency in terms of the key concepts of method and purpose.

A major difficulty with reviewing literature for any psychoanalytic research is that much of the peer reviewed published material on the PEPweb database does not use language and methodology that is recognised as part of systematic research by many from the scientific or social science community. A PEPweb search on the term qualitative for instance produced 23 references, only one of which was related to this area of research. As Hinshelwood (2013), acknowledges there is also a problem of a lack of consensus in psychoanalysis about how theories are connected to facts (Hinshelwood, 2013, p.112) and this makes the evaluation of papers difficult. In particular, writers of the expert papers can avoid openly stating a methodology and then use theory to explain clinical material. Without an explicit methodology there is no way of analysing whether or not the occurrence is significant and this can then make the conclusions hard to evaluate.

This is a cross-disciplinary problem and it is worth noting that in a recent paper (Mutz, Bornmann and Hans-Dieter, 2015) express the view that cross-disciplinary research is problematic due to an indissoluble 'paradox' (Weingart, 2000). "The interests of policy in innovation collide with the interests of science in well-defined discipline-specific research. It is science itself that hinders cross-disciplinary research" (Mutz, Bornmann and Hans-Dieter, 2015, p. 35). Defining an aim for a literature review that crosses the disciplines of psychoanalysis and social science has the following challenges.

Firstly, much psychoanalytic literature is single case based and is written to expand

or develop one of a plethora of theoretical terms without reference to systematic literature reviews or common methodological terms such as quantitative or qualitative analysis.

Secondly the literature cannot normally be searched using methodological definitions of research but only by theoretical or case content.

To manage this difference between social science research and psychoanalytic writing standard searches of social science, medical and psychoanalytic databases have been carried out for the defined terms (see Sections 2.2.2 and 2.2.3. below) and then the findings divided into four categories for analysis: quantitative research, qualitative research, expert papers and meta-syntheses.

2.1.3 Limitations of Systematic Literature Reviewing

There are several criticisms of systematic literature reviewing relevant to this research. It was developed first in a medical model and founded on a positivist approach. Hammersley (2001) argues that the assumption in systematic literature reviews is that a positivist approach is superior. The approach can fail to take account of the fact that searches, selections of relevant papers and interpretations are value laden and not objective even if they are made explicit. In this research which is both qualitative and subjective in its approach this does not pose a problem as long as the review is not taken as a positivist statement of research.

Another criticism (Bryman, 2012, p.108) is that systematic reviews are concerned with the technical aspects of studies and can focus less on interpretation and ideas. The way that this review has been conducted using a quality checklist has attempted

to provide a balance of reviewing technicalities and interpretation and ideas. This was particularly important with regard to the expert papers which are concerned with interpretation and ideas.

In a recent conclusion to a study of systematic reviews in the mental health field Forestlund, Austvoll-Dahlgren, Johansen, Lidal, Odgaard-Jensen, and Vist (2015) suggest a way of addressing some of the weaknesses of systematic literature reviews.

Within the field of mental health care, there exists some unclear and inconsistent organisation of current knowledge. This may diminish the validity and reliability of systematic reviews. It is important that review authors take care in defining the review question precisely, conduct thorough literature searches, consider each study's hypothesis, disciplinary tradition and context, and if necessary, examine which other reviews have included a study in question

(Forestlund, et al., 2015, abstract).

This literature review takes account of these suggestions.

2.2 Method

2.2.1 Eligibility Criteria

2.2.1.1 Focus. This literature review includes peer reviewed papers, books and theses that describe research into personality disorder and the psychoanalytic or emotional containment of this group by staff in psychiatric or psychotherapeutic settings, produced between 1998 and 2016.

2.2.1.2 Population. The review of the literature is restricted to a population of adults diagnosed with a personality disorder and the staff, organisations, therapists and analysts who work with them in community or ward settings. The population for the purposes of the literature review is worldwide with the literature review limited, as described in the section on Exclusion Criteria (Section 2.2.1.3 below), to research published in the English language.

2.2.1.3 Exclusion Criteria. The following topics were excluded from the literature review. Papers concerned only with:

- the experience of people with a diagnosis of personality disorder;
- therapeutic outcomes;
- training;
- specific groups such as substance misusers, forensic patients, children or those in locked units;
- diagnostics only;
- research pre-1998;
- research in languages other than English;
- research into the psychoanalytic concept of containment not specifically concerned with people with a personality disorder.

2.2.2 Information Sources

Databases searched were: PsycINFO, Medline, PubMed, CINAHL, Assia, Social Care online, PlosOne and PEPweb. Hosts used were EBSCO and OVID. References found in papers were also searched and alerts were put on Google

Scholar and other databases.

2.2.3 Search Strategy

The first search was conducted in 2014 at the beginning of the research. The search strategy consisted of an online search of papers in peer-reviewed journals and books published between 1998 and 2014. The title search terms for the search were: **personality disorder, with psychiatry, psychotherapy, psychology and psychoanalysis**. The search terms **containment, boundaries, emotion and staff attitudes** were then added. These terms were entered into the thesaurus of each database to ensure that relevant terms were identified. For instance, on CINAHL the searches on staff attitudes were: **health personnel attitudes or attitudes to mental illness. Social worker attitudes**, was added as a search term to the previous terms in the CINAHL search. References were de-duplicated with Reference Manager. The reference list of all studies was hand searched with the aid of the CASP Systematic Review Checklist (2013). The checklist can be found in Appendix C. The full search strategy is to be found in Appendix H.

The second search of the key databases listed above was carried out late in 2015. The search strategy consisted of a repetition of the online search of peer-reviewed journals and books published between 1998 and 2015 limited to 2014-2015.

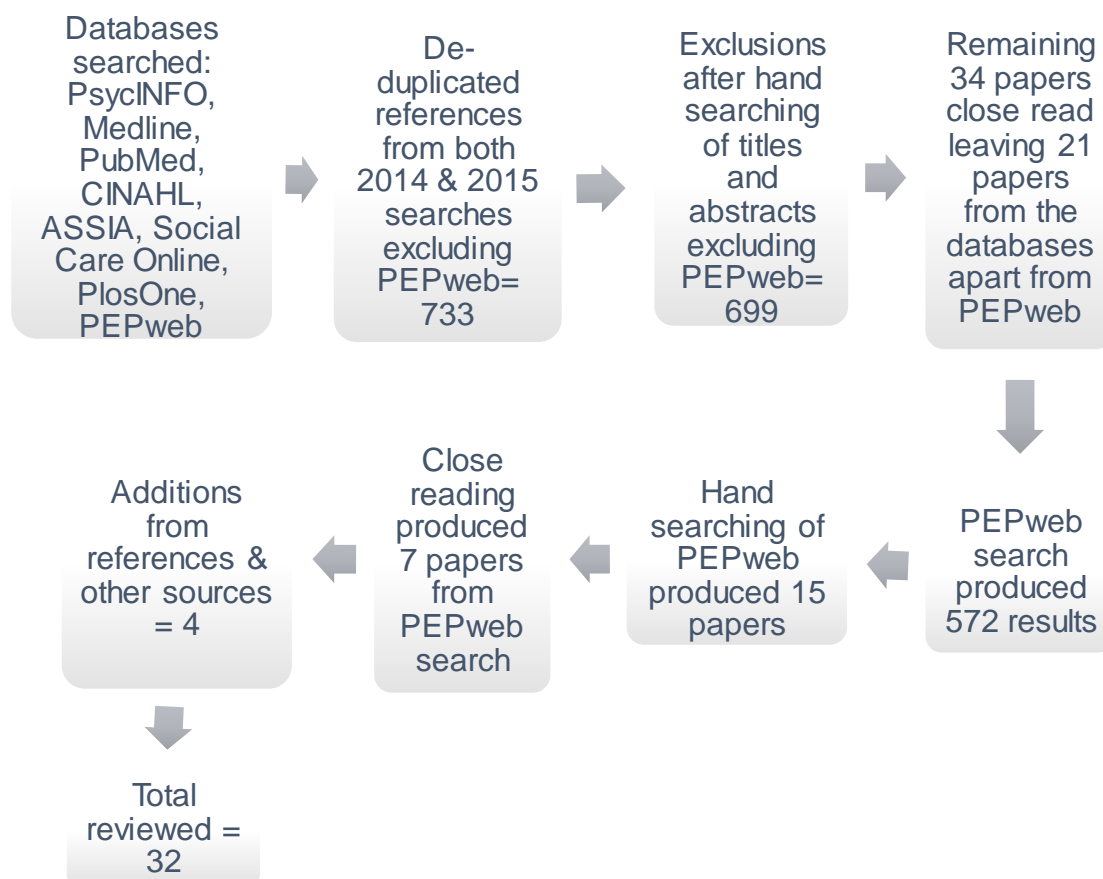
Alerts were placed on databases and Google Scholar and unpublished theses were also searched.

The first search of PEPweb used the terms, **personality disorder** and **containment** and the second search, **personality disorder** and **qualitative**.

Checking backwards and forwards citation processes was also used.

A flowchart in Figure 2 below shows the search process.

Figure 2: Identifying relevant literature (Full search history in Appendix H)



2.2.4 Study Selection

From the first search the titles of all the papers and chapters in the de-duplicated list were hand searched and the abstracts read. At each stage of the search studies were rejected if they did not meet the eligibility criteria. After exclusions according to the criteria listed 25 references remained.

The 2015 second search produced a further 42 results. The abstracts for all 42 results were read and from this hand search nine were selected.

This left 34 papers from these two searches to be reviewed. A further 13 papers were excluded after close reading leaving 21 papers from these searches to be reviewed.

The first PEPweb search produced 338 results. These were hand searched for exclusions producing 12 papers. These were then close read which resulted in a further seven being excluded by using the exclusion criteria. The second PEPweb search produced 234 results from which three papers were selected for close reading. One paper was rejected at this stage as it came into the exclusion criteria. This left a total of seven papers from the PEPweb searches.

In addition, the search of unpublished theses, a Google Scholar alert and a search of recent conference papers produced four other documents.

The total number of papers reviewed was 32.

2.2.5 Quality Appraisal

The CASP (2013) Systematic Review Checklist (Appendix C) was used as a guide to approaching the review and identifying relevant research. The CASP (2013) Qualitative Checklist (Appendix D) was used to evaluate individual studies of qualitative research. The EPHPP (Appendix E, 2010) Quality Assessment Tool for Quantitative Studies was used to evaluate quantitative research. To evaluate the expert papers a variation of the CASP checklist was used (Appendix F).

The three meta syntheses were assessed using Lewin S, Glenton C, Munthe-Kaas H, Carlsen B, Colvin CJ, Gülmezoglu M. (2016) proposed CERQual for reviewing meta synthesis (Appendix G).

For qualitative research that was duplicated in this review and a meta- synthesis it was possible to compare quality assessments and re-assess if differences were found.

2.2.6 Data Collection Process

Searches were conducted with the assistance of a librarian.

2.2.7 Data Analysis

The method used for the analysis of the literature involved the use of a relevant quality appraisal tool applied to each paper. The section on results below summarises the quality appraisal findings under each category of research: quantitative, qualitative, expert papers and meta-syntheses.

The conclusion of this literature review is a synthesis of the findings from all four types of research. Themes were identified from close reading of the texts. When themes reoccurred this was noted as were any conflicting findings. Findings were subsumed under common terms to construct themes relevant to the research questions of this research so that the data could be summarised in as few themes explaining as much of the data as possible.

2.3 Results

2.3.1 Introduction

The 32 relevant papers were divided into four categories for the purpose of quality assessment: quantitative, qualitative, expert papers and meta-syntheses. A summary of the quality assessments for each category is shown in Tables 1 to 4 in Appendix I. The papers are discussed below in each category under the headings of: characteristics, methods and analysis. Finally, there is a summary of the findings of the whole literature review.

2.3.2 Quantitative Studies

2.3.2.1 Characteristics. There were 11 studies in this category. In terms of country of origin: two studies were from Israel, one was from the United States, three were from Australia, three were from the UK, one was from Sweden and one from Ireland. Sample sizes ranged from 21 to 516. All participants were clinical or health professionals. Some studies had participant rates as low as 10% (Betan, Heim, Conklin and Westen, 2005) or 20% (Forsyth, 2007). Others achieved 60% or higher

and one paper (Bodner, Cohen-Fridel, Mashiah, Segal, Grinshpoon, Fischel, and Iancu, 2015) reported a response rate of 75.6% of social workers in one hospital. Methods of collecting data and analysis were all by questionnaire. Most used a Likert scale and analysis by SPSS. The topics of the questionnaires ranged from those measuring cognitive and emotional attitudes (Bodner et al., 2015) to two studies focussed on more particular topics: one (Betan, et al., 2005) focussed on countertransference and one on the correlation between people's fear of death and negative attitudes to people diagnosed with borderline personality disorder (Bodner, Shrira, Hermesh, Ben-Ezra, and Iancu, 2015). Five studies (Egan, Haley and Rees, 2014; Markham and Trower, 2003; Deans and Meocevic, 2006; Forsyth, 2007; Holmqvist and Armelius, 2006 and James and Cowman, 2007) used questionnaires previously used by other researchers.

Six of the 11 studies involved all staff in a locality or health provider area, two involved nurses only, one involved clinical psychologists, one psychiatrists and one ward staff only. There were a range of aims across the studies with most aiming to identify emotional and cognitive attitudes and behaviours towards those diagnosed with personality disorder.

2.3.2.2. Method. Questionnaires were used in all the quantitative studies; some used several. For instance, Bodner (Bodner et al., 2015) used three questionnaires; two measuring emotional and cognitive attitudes to people diagnosed with borderline personality disorder and one, which included a short narrative, measuring attitudes to people with borderline personality disorder as opposed to those diagnosed with depression or anxiety. The countertransference

questionnaire used by Betan, et al., (2005) had 79 items and was an instrument available to download from: www.psychsystems.net/lab. This is unavailable for verification at the time of writing this review. They used several senior clinicians to verify the statements about countertransference used in the questionnaire. One study (Bodner , Shrira, et al., 2015) used a five-minute internet based questionnaire whereas another study (Markham and Trower, 2003) used a three section questionnaire relating to different diagnostic groups with six short examples of patient behaviour which was handed to participants in the room where they remained to complete the study. There was therefore a large variation in the type and length of questionnaire used in the studies which makes comparisons difficult.

The analysis of the questionnaires varied with three studies using descriptive statistics only (Cleary, Siegfried and Walter, 2002, Deans and Meocevic, 2006 and James and Cowman, 2007). Other studies used SPSS to analyse the questionnaire responses to derive factors (Betan, et al., 2005) or to test relationships between variables to identify the extent of variance in attitudes (Egan, Haley and Rees, 2014).

In the scoring in the EPHPP table (see Appendix I) Markham and Trower (2003), Holmqvist and Armelius (2006) and Bodner et al, (2015) were scored as strong studies with Deans and Meocevic (2006), Forsyth (2007) and Cleary et al., (2002) scored as weak. The weak studies had low response rates (less than 50%) and had either not taken account of the different attributes of participants or had higher dropout rates.

2.3.2.3 Analysis. All the quantitative studies had some findings that showed staff had negative attitudes towards people with a diagnosis of personality disorder. Studies approached the concept of negative attitudes differently. Nurses were identified by Bodner, Cohen-Fridel et al. (2015) as showing more negative attitudes and less empathy towards people with a diagnosis of borderline personality disorder than psychologists and psychiatrists. Betan et al.'s study (2005) of countertransference responses found eight dimensions: overwhelmed/disorganised, helpless/inadequate, positive/special/overinvolved, sexualised, disengaged, parental/protective and criticised/mistreated. These countertransference responses were tested with responses to patients with narcissistic personality disorder. Markham and Trower (2003) similarly found that people with a diagnosis of borderline personality disorder attracted more negative responses from staff than those with other diagnoses. Attributions of negative responses were higher with people that were perceived to have higher levels of control and this also reduced staff sympathy. Forsyth's (2007) findings supported this and found a relationship between attribution combinations of controllability and stability on anger, empathy and helping behaviours. Deans and Meocevic (2006) found that almost one third of respondents said that patients with borderline personality disorder made them angry and 47% that this group of patients made them feel that they were responsible for their safety. Hayward, Tilley, Derbyshire, Kuipers and Grey (2005) found that the most distressing patients were perceived as manipulative and, in a second study, showed that aggressive and self-harming patients were scored highest for difficulty and distress. James and Cowman (2007) found the least emphasis on negative attitudes and that staff reflected ideas of being able to give adequate care to this patient group.

One study (Holmqvist and Armelius, 2006) found that patients' evocative feelings had less importance than difference between staff members' feeling patterns. A high variation in staff members' feelings was associated with a worse outcome for patients and the study suggests that for people diagnosed with borderline personality disorder splitting between staff is associated with worse outcomes. This study also suggests that rigidity of feeling in therapists contributes to worse outcomes and flexibility in feeling in therapists contributes to positive outcomes.

Several studies (Hayward, et al., 2005, Cleary et al., 2002, Deans and Meocevic, 2006, Egan et al., 2014 and Bodner, Cohen-Fridel et al., 2015) found that training was thought to help with changing attitudes to people diagnosed with borderline personality disorder. The significance of supervision was also identified in this respect as key by Cleary et al., (2002).

The only studies that referred to psychoanalytic or psychodynamic concepts were Betan et al., (2005) and Hayward et al., (2005). These concepts were countertransference and splitting. No mention was made in any of the studies of the psychoanalytic concept of containment.

2.3.3 Qualitative Studies

2.3.3.1 Characteristics. There were ten studies in this category. Three studies were from the UK, two from Sweden, two from Ireland, one from Australia and New Zealand and two from the United States. Sample sizes ranged from six to 103 although this largest sample size was an exception with the majority of studies

using sample sizes of under 21. Five of the studies were about the experiences of nurses in relation to those diagnosed with personality disorder. Three studies were of mental health staff more generally and one study focussed on case managers. The topics investigated were mainly expressed in a general way as being about the experience of managing and relating to patients with a diagnosis of personality disorder (Lee and Kiemle, 2014; Crawford, Adedeji, Price and Rutter, 2010; Bergman and Eckerdal, 2000; McGrath and Dowling, 2012; Woollaston and Hixenbaugh, 2008 and O'Connell and Dowling, 2013). Three studies had a more specific context: Wilstrand, Lindgren, Gilje and Olofsson (2007) focussed on nurses' experience of working with those who self-harm; Lee and Kiemle (2014) focussed on staff working with people diagnosed with a learning disability and personality disorder and Tillman (2006) focussed on clinicians who had the experience of a patient committing suicide. Bergman and Eckerdal (2000) extended the focus to the frame of work organisation needed to manage people diagnosed with borderline personality disorder.

2.3.3.2 Method. One study (Crawford et al., 2010) was part of a mixed method study using interviews and surveys whilst the other studies used a range of qualitative only methods. These methods were: thematic analysis (five studies), Interpretive Phenomenological Analysis (three studies) and Grounded Theory (one study). There were no studies using discourse analysis.

The sampling in all the studies was purposive and all the studies, with the exception of Treloar (2009) who used written comments, recorded interviews and used transcriptions for the analysis of the data. Eight of the nine studies used semi

structured interviews although the detail of the interview schedule was not available in the papers. No studies justified their use of this type of interview. One study (McGrath & Dowling, 2012) used a semi structured interview schedule incorporating the, “Staff-patient interaction response scale” (SPIRS) to measure empathy (McGrath and Dowling, 2012, p. 2). Another study (Wilstrand et al., 2007) used narrative interviews where people were asked to respond to two questions: to narrate a satisfying experience of someone who self-harms and to narrate an unsatisfying experience of caring for a patient who self-harms. Tillman (2006) used interviews described as open-ended, initially posing one question only about the nature of the participants’ experience and then using clarification and exploration only. One study (Crawford et al., 2010) described also using field notes although it was not clear how these were integrated into the analysis. Some studies attributed data to individual participants (Lee and Kiemle, 2014; McGrath and Dowling, 2012; Wilstrand et al., 2007 and Woollaston and Hixenbaugh, 2008) and some referred to numbers of participants as in, ‘three participants said’ (Crawford et al., 2010 and Bergman and Eckerdal, 2000). These attributions aided transparency and showed that there had not been uneven reliance on particular interviews (Potter and Hepburn, 2005). None of the studies showed the interviewers’ contribution in full in relation to quotations and only Nehls (2000) and Woollaston and Hixenbaugh (2008) gave full detail of the interview topics. This again obscured transparency and made it difficult to attend to the interactional perspective in the data. Only three studies discussed limitations (O’Connell and Dowling, 2013, Crawford et al., 2010 and Tillman, 2006).

Two studies had evidence of reflexivity by the researchers: Lee and Kiemle, 2014 and Wilstrand et al., 2007. Others acknowledged a level of research team reflection and review of the analysis of the data (Crawford et al., 2010, Tillman, 2006 and Nehls, 2000). Five studies made no reference to reflexivity (Bergman and Eckerdal, 2000, McGrath and Dowling, 2012, Treloar, 2009, Woollaston and Hixenbaugh, 2008 and O'Connell & Dowling, 2013). The lack of reflexivity meant that it was harder to assess the influence of unspoken prejudice in the studies (Bryman, 2012, p. 394).

A few studies referred to ethical approval (Lee and Kiemle, 2014, O'Connell and Dowling, 2013, Crawford et al., 2010, and McGrath and Dowling, 2012) but did not go into any detailed discussion of this. The remainder made no mention of ethics.

2.3.3.3 Analysis. Several of the qualitative studies did not offer clear reasons for their choice of type of analysis (Crawford et al., 2010, McGrath and Dowling, 2012) and few studies discussed rigour or quality with the exception of Nehls (2000). Only Tillman (2006) gave an epistemological base for the method of the research. The lack of rationale for the choice of method of analysis was emphasised by the lack of evidence of epistemological stance in most of the studies. This meant that the results of the analyses were taken at face value rather than understood within a social constructionist or other approach. This also left a difficulty with evaluation (Madill, Jordan and Shirley, 2000).

All the studies located their research in the context of previous research and explained the way in which they were adding to current knowledge. Some referred to wider policy contributions and some linked their findings to the need for further

training (McGrath and Dowling, 2012, Treloar, 2009 and Nehls, 2000). Treloar (2009) and Lee and Kiemle (2015) specifically refer to the need for further qualitative research.

The full list of themes from the studies is to be found in Appendix I, Table 2. Further analysis of these themes gave four main themes. Theme one being challenges to working with people diagnosed with personality disorder. Theme two being unreciprocated efforts and hopelessness. Theme three being feeling threatened and theme four being interest and engagement.

Challenges to working with people with a diagnosis of personality disorder were put forward in all the studies. The challenges included working with relational difficulties, self-harm, suicide attempts and unstable emotional patterns and anger. One quote in Treloar (2009, p. 31) was, "I wonder if BPD is just an excuse for bad behaviour and nastiness". Participants described patients as trying to manipulate staff (McGrath and Dowling, 2012, p.5, and Woollaston and Hixenbaugh, 2008, p. 707). It was recognised that this manipulation extended to trying to split the staff team: "I think the manipulation...the classic thing here about trying to split the staff team...it seemed to be some sort of game aimed at getting control of certain elements of the staff team" (Woollaston and Hixenbaugh, 2008, p.707) and in O'Connell and Dowling (2013, p. 29): "Another challenge I suppose is the splitting in working with different professionals. That's very hard to work with I think, for myself". Fearing for the patient's life was identified by Wilstrand et al., (2007) as a sub theme under the heading of balancing professional boundaries. One participant said: "She nearly succeeded in taking her life, the fear we felt...if I had been the one who found her

and she had been dead. It's unfair to expose another person to that; it's very hard to think about" (Wilstrand et al., 2007, p. 75).

Unreciprocated efforts and hopelessness in that staff felt undervalued and unappreciated was a common theme in all ten studies. One example in O'Connell and Dowling (2013, p.29) was, "I get burned very quickly from them...that's what I find you get burned from. Progress is so slow and I often question if there is progress at all". Similarly, in Lee and Kiemle (2015, p. 241), "It can be quite tiring cos obviously, a lot of the behaviours are repeated, over and over, and that's quite frustrating. It can feel hard cos you don't seem to move on from things and move forwards". And again in McGrath and Dowling (2012, p.5): "They usually continue with behaviours such as deliberate self-harm, threatening suicide and absconding", and, "They rope you in...chew you up and then spit you out".

Feeling threatened was a theme which included staff feeling threatened by risk of suicide, feeling that boundaries would be violated and feeling threatened by anger and aggression. Most of the studies referred to these feelings in the identified themes in some way (Wilstrand et al., 2007; McGrath and Dowling, 2012; Treloar, 2009; Woollaston and Hixenbaugh, 2008; O'Connell and Dowling, 2013; Tillman, 2006 and Nehls, 2000). Patients were accused in one study of threatening other patients (McGrath and Dowling, 2012, p.5): "They will pick out one...weaker one...get close to them...initiate relationships which can be inappropriate at times". Nehls (2000) quotes one participant who said, "You can't have relationships with these people because they're difficult" (Nehls, 2000, p.16). Woollaston and Hixenbaugh (2008) quote one participant talking about aggression who said, "This

woman went berserk...she really verbally attacked me in this meeting and publicly called me all sorts of horrible names...I remember getting out of this meeting and just sort of crying and shaking" (Woollaston and Hixenbaugh, 2008, p. 705).

More positive themes were identified in some studies (Bergman and Eckerdal, 2008; Crawford et al., 2010; Woollaston and Hixenbaugh, 2008 and O'Connell and Dowling, 2012). These positive aspects were about people with a diagnosis of personality disorder being interesting and never being boring (Crawford et al., 2010) and about patients being engaging (Bergman and Eckerdal, 1999). Positive experiences were reported about changes such as: "She got on really well here and she's working now, she's got her own flat and she hasn't self-harmed for about six months now and that's really good to see...you feel you've done some good, you've helped" (Woollaston and Hixenbaugh, 2008, p. 706).

2.3.4 Expert Papers

2.3.4.1 Characteristics. This category included the seven psychoanalytic papers from the PEPweb search and three papers from the other database searches. The papers were not described as research by the authors but as information and/or theoretical contributions to the field. Eight of the ten papers were from the UK, one was from Australia and one from the USA. In three studies single cases were used to illustrate theoretical points (Steinberg and Cochrane, 2013; Kapur, 2008 and Thorndycraft and McCabe, 2008). These single cases were either a single treatment unit, group or individual case. Three studies used two or more examples to illustrate their case (Adshead, 1998; Johnston, 2010; Johnston and Paley, 2013 and Evans, 1998) and two studies were purely theoretical or expert

opinion (McAllister, 2003 and Evans, 2014). All the papers were concerned with staff or organisational responses to people with mental illness in health care settings. Two papers were only concerned with people diagnosed with borderline personality disorder (Evans, 1998 and Thorndycraft and McCabe, 2008) whilst all other papers included reference to those diagnosed with personality disorder. The aims of the papers varied with seven papers locating their theoretical approach within psychoanalysis and aiming to show the usefulness of applying this theory to practice (Steinberg and Cochrane, 2013; Kapur, 2008; Johnston, 2010; Johnston and Paley, 2013; Seager, 2006; Evans, 1998 and Evans, 2014). One paper (Adshead, 1998) used attachment theory as the basis for approaching the topic and another used Carl Rogers' theoretical base. Five papers aimed to give guidance on how to approach care and staff support: Seager, 2006; Steinberg and Cochrane, 2013; Kapur, 2008; McAllister, 2003; Johnston, 2010 and Thorndycraft and McCabe, 2008. One paper was a response to a government report (Evans, 2014). All writers were or had been established clinicians in the field and their conclusions could be synthesised despite theoretical differences (see Section 2.3.4.3, page 63).

2.3.4.2 Method. These papers were appraised using a variation of the CASP criteria (see Appendix F).

Method is given little consideration in the papers. There is frequently a statement near the beginning that the author will use a single case or several cases to illustrate a point or points but no papers make reference to how the cases were selected. The selection appears to be opportunistic in that the authors have direct experience of the case, units or groups utilised in the paper. In one instance (Steinberg &

Cochrane, 2013) a composite case is used; the case is given a diagnosis of personality disorder. The case is presented in some detail under headings: attachment and affect regulation, self image and internal object relations and transference and countertransference implications. The paper concludes with a section on management. In other papers the cases used are from direct experience and follow an extensive theoretical background. In most papers the cases are presented as vignettes. Johnston and Paley (2013) use brief accounts of staff groups to make particular points: an open and shut case, 'proper poorly' and support is critical. In one paper (Adshead, 1998) three very short vignettes are used under headings: management problems as attachment behaviour with one vignette linked to deliberate self-harm and one to anger and violence. A third vignette is under the heading, "Secure attachment fostering change" (Adshead, 1998, p. 68).

Four papers do not mention reflexivity or countertransference in any way, (Johnston, 2010, Johnston and Paley, 2013, Seager, 2006 and McAllister and Walsh, 2003). In one paper (Adshead, 1998) there is generalised reflection about the staff and institution, not reflexivity on the part of the author about their role. This is common to some of the other papers. Only Steinberg and Cochrane, 2013; Kapur, 2008; Thorndycraft and McCabe, 2008 and Evans, 1998 include reflexivity about their own role. In one paper (Thorndycraft and McCabe, 2008) the term countertransference is used under the heading of, "Reflections" (Thorndycraft and McCabe, 2008, p.174), and for the purpose of this review this is taken to mean reflexivity.

None of the papers mention ethical issues or ethical approval and yet the use of a composite (Steinberg and Cochrane, 2013) implies that ethical thinking has been done.

Overall there is poor attention to the explanation of method in these papers. The focus of the assessment was on a value score concerned with ideas and interpretation and the contribution to knowledge (see Section 2.3.4.3, page 61 and Table 3, Appendix I).

2.3.4.3 Analysis. The conclusions of these expert papers are statements relating to the theoretical background, the vignettes and the opinions of the authors. They are not written in the form of evidence but in the form of opinion or guidance. This makes any comparison with social science research results problematic. It is possible to assess the conclusions of these papers as individual contributions to research in the sense that they focus on interpretation and ideas (Peritz, 1980, see Section 2.1.2) and set out to make a contribution to knowledge. They cannot be assessed with the same technical criteria as other social science research but can be evaluated by a sense of value and by further research. This evaluation of value, being a judged significance of the theoretical application to practice with sufficient case evidence, was used in the table (Appendix I, Table 3) to give a score to the quality of the paper. The use of reflexivity was also taken account of in the scoring. From this process four papers (Steinberg and Cochrane, 2013; Kapur, 2008; Thorndycraft and McCabe, 2008 and Evans, 1998) were scored as strong. Two papers (McAllister, 2003 and Seager, 2006) were scored as weak as there was no clinical case material and no reflexivity. All the other papers were scored as medium

as they had value in relation to practice, used some reflexivity and/or some use of clinical material. The paper written in response to the Francis Report (Evans, 2014) was scored as moderate as there was no direct clinical material and yet a well worked through theoretically based opinion.

Taking a thematic approach to analysing the conclusions of these papers three themes emerged: the value of psychoanalytic and other theories as a tool for understanding clinical material and contributing to practice; the value of reflective space for staff; containment and bearing disturbance.

Psychoanalytic and other theories were used as a tool for understanding clinical material in all the studies. Johnston and Paley (2013), Johnston (2010) and Thorndycraft and McCabe (2008) use psychoanalytic theory to demonstrate an understanding of patients and to underpin proposals for reflective groups for staff. Evans (1998 and 2014) uses psychoanalytic, mainly Kleinian, theory as a basis for thinking about the management of patients and about institutions as a whole. Steinberg and Cochrane (2013) use psychoanalytic theory to think about understanding a composite case and the implications of the theoretical understanding for management. Kapur (2008) also uses a psychoanalytic and a specifically Kleinian and post Kleinian framework to understand the management and leadership styles that could enhance the work environment. Adshead (1998) uses attachment theory as a basis for understanding the therapeutic relationship. McAllister and Walsh (2003) use the theory of Carl Rogers to devise a new framework for care which includes the elements of: containment, awareness, resilience and engagement. Psychoanalytic theory is the most frequently used theory in these expert papers.

The value of reflective space for staff is emphasised in all the papers. Johnston and Paley (2013) state: "Reflective practice is not primarily staff support; but it is supporting staff with the disturbance evoked by their patients" (Johnston and Paley, 2013, p. 181). Johnston (2010) writes that the purpose of reflective groups is:

To evoke an ordinary resonance or echo in the emotional experience of staff about the kind of problems that the patient is struggling with without it becoming personal therapy. The idea is to foster empathy and shared humanity but also to try to allow a more discomforting identification to allow more difficult feelings to emerge

(Johnston, 2010, p. 245).

Several of the papers present reflective groups as a solution to the difficulties of managing people diagnosed with personality disorder (Kapur, 2008; Johnston, 2010; Johnston and Paley, 2013 and Thorndycraft and McCabe, 2013). No paper contraindicates reflective groups for staff. However, there is little material evaluating the impact of reflective groups although mention is made of one forthcoming paper in Johnston and Paley (2013) which evaluates reflective groups and finds that they do not lower levels of stress or burnout (Johnston and Paley, 2013, p.184-185). They cite the positives of reflective practice as being about linking staff from different professions and/or units and giving an increased psychological awareness of the impact of reflecting on the disturbance of patients as it affects professionals which leads to improved care. There is no evidence of this given in the paper.

The use of the concept of containment as being about the bearing of disturbance and processing primitive defences such as splitting and projection, idealisation and denigration is found in several papers: Johnston, 2010; Evans, 1998; Evans, 2014; Seager, 2006 and Steinberg and Cochrane, 2013. Another paper, McAllister and Walsh (2003), uses the term containment to describe a process of holding which is physical and involves, “Facilitating the expression and release of pent –up tensions and then aiming to seal off problems so that they no longer leak out into the present” (McAllister & Walsh, 2003, p. 41). The definition of containment used in this paper has a theoretical base in the theory of Carl Rogers and is closer to Winnicott’s holding than to Bion’s idea of containment. The use of the term containment varies throughout the expert papers but in over half the papers in this group the concept of containment of feelings is present. It is not used in a consistent way throughout the different papers but the most common use reflects a psychoanalytic definition.

Although four papers in this expert category were scored as strong and do include some reflexivity and the subjects of psychoanalytic theory, containment and the bearing of disturbance there are general weaknesses throughout this category. In terms of the technical quality of the research there is little explanation or consideration of method and little systematic analysis of clinical material. However, these papers are strong on interpretation and ideas.

2.3.5 Meta- Syntheses

2.3.5.1 Characteristics and Methods. There were three relevant meta-syntheses produced by the searches and included in the 32 papers examined for this review. These were: O’Key and Das Nair, 2014; Sansone and Sansone, 2013 and

Noblett and Henderson, 2015. Noblett and Henderson (2015) conducted a general review of literature concerning the attitudes and stigma held by healthcare and mental healthcare professionals towards people with mental illness. The review did not exclude personality disorder. Their exclusions were: dementia, developmental disorders and learning disabilities. They searched five databases and selected 38 papers and undertook a narrative review.

The Sansone and Sansone literature review did not impose any restrictions on date of publication and used search terms such as, “borderline personality, attitudes, reactions and stigma” (Sansone and Sansone, 2013, p.40). The review aimed to examine the perceptions and reactions of mental health clinicians towards patients. They searched three databases and do not give a total number of papers selected. The results were written up according to the professional groups participating in the research: psychiatric nurses, mixed samples of mental health clinicians and psychotherapists.

O’Key and Das Nair’s (2014) unpublished Doctorate in Clinical Psychology literature review is a systematic review of qualitative research into staff perspectives regarding working with people with a personality disorder diagnosis. The review aimed to identify the key issues that staff report in relation to working with people with a diagnosis of personality disorder and how these issues are being addressed. They note that in order to integrate qualitative studies they had to bring together studies with a range of epistemologies. Mixed method papers were included in the review but the quantitative data was not considered. They excluded papers on service user perspectives, methodological or theoretical papers, papers on treatment evaluation,

papers referring to multiple diagnoses where personality disorder was not identifiable as specific. They searched seven databases and identified 12 for review. Each paper was graded using the quality assessment framework produced by the UK National Centre for Social Research.

2.3.5.2 Analysis. Noblett and Henderson (2015) found that mental healthcare staff were less likely to have negative attitudes towards those with mental illness than general medical professionals. However, they found that results did differ according to how they were measured and that when social restrictiveness was measured mental health professionals were more positive towards people with mental illness but less positive towards outcomes than other healthcare professionals. This study therefore contributed something to the background information for this research but all the papers listed were too general to identify a specific finding or theme that related to personality disorder.

Sansone and Sansone (2013) found that most studies were done amongst psychiatric nurses (they state $n=10$ but do not state the total number of studies found) and that half these studies were undertaken in the United Kingdom. The meta synthesis summarised the findings of each study but only briefly commented on the themes. The writers concluded that the research involving psychiatric nurses showed, with the exception of one Greek study (Giannouli, Perogamvros, Berk, Svigos and Vaslamatzis, 2009), that these clinicians perceived patients with borderline personality disorder as, "Dangerous, powerful, unrelenting and more difficult to take care of" (Sansone and Sansone, 2013, p. 42). All other studies identified nurses as being likely to respond to such patients with, "Social distance,

less helpfulness, less empathy, more negative emotions and attitudes, and anger” (Sansone and Sansone, 2013, p. 41). Sansone and Sansone (2013) reported that studies with mixed samples of mental health clinicians had similar findings with all clinicians finding the group difficult to deal with. However psychiatric nurses had the lowest scores in studies that compared groups of staff in terms of empathy and overall caring attitudes. Social workers had the highest ratings on these qualities as found in one study which took place in academic medical centres (Black, Pfohl, Blum, McCormick, Allen, North, Phillips, Robins, Siever, Silk, Williams and Zimmerman, 2011). Studies, which dealt with psychotherapists’ and clinical psychologists’ responses to patients with borderline personality disorder, of which they only found three in total, reported that these staff had negative attitudes to this group of patients and felt less satisfied in their therapeutic role. One study (Jobst, Horz, Birkhofer, Martius and Rentrop, 2010) found that therapists often experienced anxiety and demonstrated some prejudice in working with patients with borderline personality disorder. The paper notes that there have been no particular studies of psychiatrists’ attitudes to patients with borderline personality disorder.

The study that produced different results (Giannouli et al., 2009) in terms of finding that there were no negative attitudes by respondents towards people diagnosed with borderline personality disorder examined 69 inpatient and outpatient psychiatric nurses’ responses to a 23 item questionnaire. However, the study surveyed staff who had limited contacts with borderline personality disorder patients. The study took place in Greece. This study was the only one found by Sansone and Sansone (2013) that did not have any negative responses. The Giannouli et al. (2009) study was specific to those diagnosed with borderline personality disorder rather than

personality disorder as a whole, to one group of clinicians with limited contact with people diagnosed with personality disorder and was based in a different cultural context to this research.

Limitations of the Sansone and Sansone (2013) review are that although they note that samples are small overall there is no methodological detail or further quality assessment of the research. In terms of this research a limitation of Sansone and Sansone (2013) is that the study is specific to borderline personality disorder rather than all personality disorders. Their review, although providing a useful synthesis of findings, has different aims to this review.

O'Key and Das Nair (2014) found a range of qualitative methods that had been used in studies: thematic analysis, phenomenological analysis, grounded theory and discourse analysis with two studies describing a descriptive approach without naming a method. The four themes that this meta-synthesis found in the papers were: attributions of intention; unreciprocated efforts and hopelessness; feeling under threat and 'never boring'. They found that all the papers suggested challenges to working with patients with personality disorder. No papers reflected on the role of the researcher within the analysis and none of the studies referred to the epistemological stance taken. This affected the assessment of quality in that the subjective bias of the researcher was not made explicit.

This meta synthesis was of good quality when evaluated according to the CERQual criteria (see Table 4, Appendix I). Using the exclusion criteria for this literature review

six papers from this meta synthesis were relevant and were also duplicated in the searches.

Whilst useful in terms of identifying qualitative research in this field the number of studies that have relevance to this review is limited (n=6). The quality of the papers was also not easily assessable. The findings of the studies were used primarily to recommend further training rather than further research. O'Key and Das Nair (2014, p. 40) also concluded that the synthesis revealed a lack of critical literature around the assumptions underlying staff and researcher accounts of diagnosis and personality disorder. They recommend that future research should take on a more social constructionist framework and pay attention to wider systems impacting on staff experiences.

2.4 Conclusions from the Literature Review

This systematic literature review aimed to identify recent (1998 – 2015) research and psychoanalytic writing about staff and institutional attitudes to people with personality disorder and in addition to explore to what extent the psychoanalytic concept of containment applied to this context has been investigated. The review showed that the psychoanalytic concept of containment has rarely been mentioned in research. When it has been mentioned it has been mainly in expert papers which are not categorised as qualitative research but are mostly theoretical and clinical papers which give guidance for practice.

The studies reviewed showed limitations in terms of method. All the quantitative studies used questionnaires as their method of investigation. There were no experiments. The majority of the qualitative studies used thematic analysis with others using Interpretive Phenomenological Analysis and Grounded Theory. No relevant studies used discourse analysis or narrative analysis. In the expert papers either single cases or several cases were used. The lack of explanation of method in these papers meant that relevance was hard to assess. They did use reflexivity and countertransference more than papers in the other categories. Many of the expert papers made extensive use of psychoanalytic ideas and related these closely to their chosen clinical material.

Several gaps in research are evident from this literature review. Firstly, in terms of method there is not a single study using discourse analysis. Secondly, four qualitative studies refer to the need for further qualitative research (see Section 2.3.3.3). Thirdly, psychoanalytic ideas were only considered in two of the quantitative studies and one of the qualitative studies. In the expert papers psychoanalytic ideas were a common base but no paper in any category focused on psychoanalytic containment.

The three meta syntheses showed that staff attitudes to people diagnosed with personality disorder have been researched. There are perhaps 40 studies, if date parameters are altered from those used in this review (one meta synthesis was not specific on numbers found). Twelve qualitative studies were found by O'Key and Das Nair (2014).

The recurring themes from all four categories of research examined in this review are summarised in Table 1 (page 73). The only theme found in all four categories of research was that of negative attitudes, difficulty and distress. The other themes describing what could be defined as negative feelings: attributions of intent, unreciprocated effort and hopelessness and feeling under threat were found in all categories apart from the expert papers. This can be accounted for by different use of language. In the expert papers terms such as splitting between staff and bearing disturbance could be renamed as difficulties or negative attitudes. Whilst these differences in ideas and interpretation of attitude are there they do not interfere with an overall assessment of research in all categories as showing evidence of negative attitudes and difficulty in dealing with people diagnosed with personality disorder.

The research does not entirely omit positive attitudes in that interest is found as a theme in three out of the four categories and may be implicit in the expert papers acknowledged by the fact that there is sufficient interest for the papers to be written. The dominance of the difficulties is nevertheless clear and it is this area that is the context for the current research.

Specifically, this literature review shows a gap in qualitative research into the themes of psychoanalytic theory, reflective practice, containment and bearing disturbance. This lack of systematic qualitative research using psychoanalytic theory and investigating staff containment with regard to people diagnosed with personality disorder is the gap which this research aims to target.

In addition, none of the research identifies impediments to psychoanalytic containment or mentions the impact of power and control on the capacity for

reflection or containment. However, Evans (2014), in his paper written as a comment on the Francis Report (2013), talks about the erosion of clinical authority by the target driven culture and relates this to the messages from Menzies (1960) never having been adequately implemented. This thesis uses qualitative research to explore how psychoanalytic containment can be eroded or avoided. The literature review did not reveal other research in this area.

Table 1: Summary of themes from literature reviews

Themes	Review – Meta Syntheses	Review- Quantitative	Review- Qualitative	Review- Expert Papers
Attributions of intention impact on anger, empathy and helping behaviours	x	x	x	
Unreciprocated efforts and hopelessness	x	x	x	
Feeling under threat	x	x	x	
Interest -‘never boring’	x	x	x	
Negative attitudes, difficulty and distress	x	x	x	x
Psychoanalytic theory				x
Splitting between staff		x		x
Training & supervision		x		x
Reflective practice				x
Bearing disturbance - containment				x

3

Methodology

This chapter includes an account of the methodological approaches considered for this research; a description of the epistemological base for the research; a justification for the use of the selected qualitative approach and an outline of the approach chosen. Also considered are the quality and validity of the research in the light of some other models. This is followed by an account of ethical considerations and procedures. A description and justification for the sampling and recruitment of participants follow this. The interview structure and technique used is then justified and explained. The method used for data analysis and the steps followed for the analysis are described.

The chapter will outline the psychoanalytic discursive approach used for this research; show how it fits within a broad ethnographic framework; and describe how reflexivity is a key part of the methodology.

3.1 Methodological Approach

3.1.1 Research and Psychoanalysis

It was important in searching for a methodology to examine various approaches to research and psychoanalysis in order to determine a method for this research. Taylor (2010) uses Bion's introduction (1970, p. 125) of Keats's term

negative capability to identify the kind of observational attitude that psychoanalysis requires:

Negative capability in its ideal form includes a willingness to accept the kind of emotional disturbance which arises as a consequence of an open attitude. It is also attuned to and knowledgeable about the matter in hand. However this knowledge is kept in reserve

(Taylor, 2010. p. 405).

Taylor (2010) uses the word *equipoise* to refer to the position of the researcher. He refers to both the acceptance of emotional disturbance and knowledge. The link is to the psychoanalytic clinical method and to the methodology of this research.

Hinshelwood in his book *Research on the Couch* (2013) comments that outcome studies aiming to provide measures of effectiveness, such as the Menninger Project (Menninger, 1946) and the Luborsky and Penn Psychotherapy Project (Luborsky and Crits-Christoph, 1988) have led to the development of more process orientated research (Bucci and Maskit, 2007). Schedler's work using the Schedler-Western Assessment - Procedure (SWAP) based on a Q sort method has also refined outcome research into a more detailed analysis of process (Schedler, 2002). However, Schedler's work is again an outcome study in the sense that it is about finding evidence of effectiveness. These studies of effectiveness do not investigate the concepts of psychoanalysis or how they are used but rather the effectiveness of treatments based on psychoanalytic ideas and, because of this, the methods used are less relevant to this research.

Tuckett (2008) has carried out ethnographically based investigations, using focus groups and grounded theory, into what psychoanalysis is and what a psychoanalytic process is and has used lengthy psychoanalytic group processes to investigate the clinical culture, attitudes and beliefs of clinicians. The research focuses on the social anthropology of the profession. The approach concentrates on what is, in an empirical sense, and does not further explore the concepts of psychoanalysis or how they are used. Tuckett's research provides important confirmation of the psychoanalytic model, but has perhaps, because of the nature of the psychoanalytic subject, failed, as Hinshelwood suggests (2013, p.29), to evaluate the nature and function of psychoanalysis and psychoanalytic concepts. Grounded theory itself is an explanatory method which has more emphasis on constructing theory (Charmaz and Henwood, 2008) and less emphasis on process and the reflexivity of the researcher than a discursive approach. The grounded theory method would not allow for an investigation of containment and the enquiry into the processes of defences against it that was required for this research.

The June 2015 issue of *The International Journal of Psychoanalysis* included the publication of papers concerning research currently being carried out in the psychoanalytic community (Birksted-Breen, 2015). As Birksted-Breen points out in the editorial (p. 509) almost all these papers (Willemsen, Inslegers, Meganck, Geerardyn, Damset and Vanheule; Taylor and Leuzinger and Bohleber, 2015) proposed new methodologies. Other papers used methodologies that had been developed over the last previous fifteen years (Reith; Hinze; Rudden and Bronstein; Bernardi; Perez, Crick and Lawrence, 2015). Notable was the paper by Perez, et al. (2015), a thematic analysis of initial consultation reports. This methodology was, as

the writers' state, unusual in the attempt to use a depth of subjective experience and to include a complexity of experience that is not captured by standardised research methods. The subjectivity and complexity of the psychoanalytic process were used as a justification (Perez, et al., 2015, p.661) for the use of a qualitative approach. Although a thematic analysis based on the Braun and Clarke model (2006) one of the research questions concerned how the reports were written (Perez, et al., 2015, p. 664). This study did not venture into discourse analysis and ideas of positioning yet the question implied a possible use of such a methodology in that rather than focusing on themes the question was raised about how people expressed themselves.

Bernadi (2015) reviewed controversies about psychoanalytic research, hermeneutic and empirical and described a triangulating model, 3-LM, which was used by the International Psychoanalytic Association in the Clinical Observation Committee as a process involving group work to analyse patient transformations (Bernadi, 2015, p. 739). This is a mixed quantitative and qualitative method that Bernadi states allows clinical discussion groups to triangulate observations made by participants using different theoretical models. He finally advocates systematic research and dialogue with other disciplines: "Not to close ranks and instead allow contact with other methodologies," (Bernadi, 2015, p. 748), which he sees as allowing psychoanalysis to explore itself and to keep psychoanalysis relevant to the current state of knowledge. This is a plea for continuing research, rather than a proposal for a particular method, but lays the ground for the possibility of using the methodology of discourse analysis in this research.

Geertz's (1973) description of ethnography as thinking and reflecting (taken from Ryle, 1949) and the activities as thick description, ways of building up a picture by inference, is also appropriate to this research. Ethnography is both observational and interpretive. The stance involves seeing behaviour, or language, as symbolic not subjective or objective. The observational research of Hinshelwood, Skogstad, Donati, Rees, Chiesa and Edwards (in eds. Hinshelwood and Skogstad, 2002) using the method of infant observation does rely on a relatively neutral non-participating observer and a follow up seminar focused on interpretation. Hinshelwood and Skogstad (2002) argue that this psychoanalytically aware ethnographic approach is an appropriate research method and that the findings can be used to assist organisations to be more sensitive and less defensive:

The observer endeavours to keep an eye on three things: the objective events happening, the emotional atmosphere; and his/her own inner experiences, the whole area of what in the psychoanalytic setting would be called 'countertransference'. All these areas of observation together reflect the qualities that make up the 'culture' of the organization

(Hinshelwood and Skogstad, 2002.p.22).

The infant observational method is frequently used in psychoanalytic trainings and is a move towards reflecting on subjectivity. Urwin (2007) developed a more systematic research method of infant observation by combining observation with semi structured interviews to investigate the formation of mothering identities. In her work she underlines the difference between textual analysis of interviews and the

processes of thinking about emotional dynamics. Researcher accounts rather than audio transcriptions were used for the data analysis.

The focus on the countertransference of the researcher is reflective practice, and the focus is important to this psychoanalytic research. Alvesson and Skoldberg (2009) state that there are a variety of uses of reflection in research methodology, which come from various epistemological backgrounds including ethnographical, critical phenomenological and social scientific studies. They define reflective research as having two basic characteristics: interpretation and reflection (Alvesson and Skoldberg, 2009, p. 9). According to Alvesson and Skoldberg (2009, p. 11), there are four elements to reflective research: the use of systematic techniques; clarification of the importance of interpretation; awareness of political and social context and reflection in relation to the problem of authority. The method they outline is broadly defined and does not conflict with using a discourse analysis approach. However, Alvesson and Skoldberg's approach to reflective practice does not encompass ideas of countertransference in the sense of receiving projective identifications and understanding them. It is therefore limited in its application to this research and to psychoanalytic research in general.

Midgley (2006) and Holmes (2013), in a more specifically psychoanalytic way, advocate the use of countertransference in qualitative research. Midgley (2006) links the use of countertransference to the hermeneutics of Lorenzer (1986) and Oevermann (1993) and in particular to the idea of putting the researcher's emotional responses at the heart of the data collection process. There is mention of projective identification in that there is a reference to the researcher being pulled into the

dynamics of the individual and to a paper by Tietel (2000), which refers to the researcher as a projective surface. This approach brings research closer to the idea of discovering what is unconscious or hidden and to an exploration of affect. It is closer to the approach needed for this thesis.

Psycho-social researchers (Beedell, 2009; Boydell, 2009; Clarke & Hoggett, 2009; Elliott, Ryan and Hollway, 2012; Frosh, 2010 and Hollway, 2013) have increasingly seen reflexivity, including the use of a psychoanalytic idea of countertransference, as part of the production of knowledge. Elliott et al. (2012) link reflexivity, supervision and responses to research encounters to two disciplines: ethnography and psychoanalysis. They consider that writing field notes and further reflection on them is central to the reflexive production of knowledge and describe this process as, “Containing,” in some cases (Elliott et al., 2012, p. 440). They also stress the relevance of psychoanalytic methodology to reflexive research. Their approach is closest to the reflexive method chosen for this research (see Section 3.1.6, page 91).

There remains a struggle within psychoanalysis over whether it is a science, whether it belongs to hermeneutics as a discipline or to a third stance of hyper complexity where an amount of indeterminacy has been accepted (Green, 2000, p.22). Hermeneutics, defined as, “The art or science of interpretation” (The Shorter Oxford Dictionary, 1983), has been an approach argued for by philosophers and psychoanalysts (Habermas, 1968, Ricoeur, 1970, Klein, 1973 and Schafer, 1976) as being an appropriate way of researching psychoanalysis. It has however often been seen as being in opposition to a more scientific approach. Hinshelwood (2013), Bell (2009, p.335) and Taylor (2010) argue for a dual approach, which encompasses

hermeneutics and the idea of scientific knowledge. Hinshelwood likens this mixture to a vertical and horizontal approach to the subject (Hinshelwood, 2013, p. 85). There is a theory to prove or disprove and there is an investigation into meaning. The combination of hermeneutics with the exploration of countertransference and the examination of a hypothetical base to research are closer to what is needed in this particular study but hermeneutics assumes an idea of fixed truth or meaning, which a social constructionist approach avoids by taking a more investigative stance.

In my research the questions are focused on an investigation into the psychoanalytic idea of containment. The investigation is into a theoretical construct of psychoanalysis, which in itself is a social construct. In a sense the research is testing whether there is a construct of containment or not, what the qualities of containment might look like and what strategies may be used to avoid it. Although hermeneutics has strengths as an approach in terms of being about the interpretation of meaning it does rely on a concept of truth and meaning. In the case of my research the concept of containment itself is subject to scrutiny in terms of a process.

3.1.2 Psychoanalysis and discourse analysis: epistemology

Any investigation into meaning though relies on a concept of meaning itself and Kristeva, a psychoanalyst and professor of linguistics, in *The Sense and Nonsense of Revolt* (1996) proposes a way of investigating meaning:

It is a matter of pushing the need for the universal *and* the need for singularity to the limit in each individual, making this simultaneous movement the source of both thought and language. "There is meaning": this will be my universal. And "I" use the words of the tribe to inscribe my singularity. *Je est un autre* ("I

is another"): this will be my difference, and "I" will express my specificity by distorting the nevertheless necessary clichés of the codes of communication and by constantly deconstructing ideas/concepts/ideologies/philosophies that "I" have inherited. The borders of philosophy and literature break down in favor of the *process* of meaning and the speaking being, meanings emitted and values received.

(Kristeva, 1996, in Portable Kristeva ed. Oliver, K., 2002, p.432)

Concentrating on the process of meaning, Kristeva identifies elements for research one of which is intertextuality. She states that this approach came from her reading of Bakhtin (1981) and that it encourages one to read a text as an intersection of other texts and to show how much the text is indebted to its outside. For her this process of interpretation shows the inauthenticity of the writing subject or speaker (Kristeva, 1998, p.446 in Portable Kristeva, ed. Oliver, 2002). She makes a further major point about a distinction between the semiotic and the symbolic. The semiotic being the sign, rather than the thing itself. Again meaning is thought of as a process, not a structure.

Kristeva's approach has become known in psychoanalysis as part of the French school. This French psychoanalytic trajectory includes much Lacanian thinking. Lacan (1966) describes the function of language as being:

Not to inform but to evoke. What I seek in speech is the response of the other.
What constitutes me as a subject is my question. ... I identify myself in

language, but only by losing myself in it like an object" (Lacan, 1996 in Lacan, 1982 p.86).

Lacan understood the symptom to be structured like a language, just as he saw the unconscious structured in this way (Lacan, 1979, p.20). Although Lacan is referred to as a post structuralist, Branney (2008) acknowledges how structuralism is important to Lacan. Lacan himself links his view of language and psychoanalysis to a structuralist approach when he quotes Levi-Strauss (Lacan, 1996 in Lacan, 1982, p.72) and ethnography as working with a similar approach. It is possibly because she saw the structuralist approach as limited to ideas of a fixed, if hidden, meaning that Kristeva developed her own ideas of discourse seeing structuralist ideas as a limitation to both psychoanalysis and discourse analysis. Not much has been made of Kristeva's approach to discourse in English speaking psychoanalytic circles. As she states: "Psychoanalysts in the United States are scarcely interested in Freudian psychoanalytic research in France" (Kristeva, 1998, p.447 in Portable Kristeva, ed. Oliver, 2002). Both Lacan and Kristeva's work do though mean that there is a long established link between psychoanalysis and discourse analysis.

The link was taken up by Parker (1997a) in his paper, Discourse Analysis and Psycho-Analysis, although he does not, in this paper, mention Kristeva. He focuses on eight aspects of transformative theoretical work that would need to be applied to psychoanalytic writing to move it into a human science frame:

A move to a human science frame, a turn to collective phenomena, a shift away from always intentional authorial responsibility, a reading of texts as

reconstructions of the past, an attention to researcher subjectivity, an understanding of the text as 'other', an emphasis on language in re-framing accounts, and a sensitivity to the cultural specificity of analytic vocabularies

(Parker, 1997a, p. 479).

According to Parker, these aspects of theoretical work enable a social constructionist approach, rather than maintaining a focus on intentional authorial responsibility. In his book, *Psychoanalytic culture: Psychoanalytic discourse in Western society*, Parker (1997b), considers ways in which psychoanalytic thinking has permeated culture and society. He is clear that he considers psychoanalysis to be socially constructed and notes that it is changing (Parker, 1997b, p.256). In this book he discusses Kristeva and her search for a balance between language as meaning (symbolic) and language as non-meaning (semiotic) whilst always seeking ways of extending the limits of the signifier (semiotic) (Parker, 1997b, p. 227 and Lechte, 1990, p.208). Parker (1997b, p.227) argues that the answer is that all the mental processes that Kristeva discusses are constructions in discourse; it is just that some constructs are more enduring constructions.

Social constructionism is the epistemological stance of my research and in investigating the concept of containment I take this concept to be a relatively enduring construct of psychoanalytic discourse.

Also relevant to the epistemology of the whole initiative of this thesis is Kristeva's idea, which follows her approach to the social constructionism of language, of

understanding writing as an individuating, “Experience of limits” (Kristeva, 1980 p.137).

3.1.3 Discursive psychology and psychoanalysis

Discursive psychology emerged in the 1980s (Potter and Wetherell, 1987) as a critique of cognitivist psychology. This critique involved identifying assumptions made by cognitive psychologists including that talk is a route to cognition, that cognitions are based on perceptions and that an objective perception of reality is theoretically possible (Willig, 2001). Discourse analysis is more than a methodology; it is also a critique of mainstream psychology. It is a way of analysing language and text that investigates the construction of social reality.

Branney (2008) writes about the emergence of a form of discursive psychology, which combines discourse analysis and psychoanalytic theory. He identifies three different psycho-discursive approaches: (i) Hollway and Jefferson’s Free Association Narrative Interview method; (ii) Billig’s Psychoanalytic Discursive Psychology; (iii) Parker’s Lacanian excursions into social psychology. Parker (2015, p.239) identifies two strands of psychoanalysis and discourse analysis, one being Lacanian (Owens, 2009) and one being Kleinian which he sees as primarily used by Hollway and Jefferson (2000 and 2013).

In using the term “Free Association Narrative Interviews” Hollway and Jefferson (2013) describe a method of open ended questioning interviewing developed from the biographical interpretive method. This method has emerged from psychosocial studies and replicates, as they point out, the form of psychoanalysis and free

association. The invitation to the interviewee is to say whatever comes to mind. The significance of my research is not about producing a narrative per se but rather about discovering the response, however obscured, to the material and to the interview itself. It does not therefore seem accurate to name my method Free Association Narrative Interviewing, as Hollway and Jefferson have done, but to shorten the title of the method to free association or open interviews. Hollway and Jefferson, (2013, p. 151) state that, as they have implemented their method, they have become more aware of the threads of emotional experience and defences that are in play in the interviews. However, they acknowledge that the expression of repressed material is not their central aim. Their approach is described by them as critical realism and aims to show, "The relationship between people's ambiguous representations and their experiences" (Hollway and Jefferson, 2013, p.3). They do though emphasise that understanding the research subject can only be known through another subject, the researcher. I make use, in my research, of reflections on my own countertransference and use reflexivity and countertransference to focus on understanding projective identification and other defences in the interviews. My research aims to show the processes at work in the interviews and in myself as researcher rather than to achieve a state of understanding.

Billig (2006) recommends, "The use of two seemingly opposing psychological approaches: discursive psychology and psychoanalytic theory" (Billig, 2006, p. 18). He describes discursive psychology as reinterpreting psychological concepts in terms of language based activities and psychoanalytic ideas as stressing what is unsaid. However, he states that a simple combination of the two approaches is unsatisfactory. What Billig (2006) does is to articulate a way of identifying Freudian

theoretical concepts such as defence mechanisms, denial and projection as patterns of discourse (Billig, 2006, p.23). He describes a discourse of attribution as a common way in which such Freudian concepts are shown by language, calling an example of this the 'third person effect' (Billig, 2006, p.23). He describes the third person effect as a pattern of projection and attribution by which people project their disowned feelings onto others. He gives the example of how people can claim that they can resist the persuasive powers of the media whilst stating that others do not.

Parker (2015) explores the field of psychosocial studies (Parker, 2015, p.254) attempting to steer it towards critical discursive psychology. Psychosocial studies have used a combination of the concepts of the individual and the social and built on the traditions of the use of discourse in psychology. Boydell (2009) in her paper, "Analysing discourse psycho-socially", combines discursive psychology with a psychodynamic approach in her work on metaphor and sees this as consistent with the approach of Hollway and Jefferson (2013). Parker (2015) points out (Parker, 2015, p.255), that discourse analysis and discursive psychology, from his point of view, have failed to resolve fundamental questions concerning reflexivity and research (Parker, 2005, 2012). This is debatable as Hollway and Jefferson (2013) used reflexivity in their research (Hollway and Jefferson, 2013, p.60) and discuss (Hollway and Jefferson, 2013, p.158) the use of the idea and term countertransference which is in itself part of psychoanalytic discourse. They comment (Hollway and Jefferson, 2013, p.159) on Frosh's (2010, pp. 213-4) distinction between the clinical use of the term and the use that is made of the term in their research and come to the conclusion that it could be better to find an alternative term either using Hunt's (1989) term, 'using (the researcher's) subjectivity

as an instrument of knowing' or 'using one's emotional responses' (Urwin, 2007; Hollway, 2011). Parker (2015, p.255) dismisses this as regressive and promotes a Lacanian view that focuses on the 'indeterminacy' of discourse and subjectivity as something that arises in discourse and in relation to politics (Parker and Pavon-Cuellar, 2014).

Parker (2015, p.269) suggests that psychoanalysis, particularly Lacanian psychoanalysis, can be taken seriously as a critical discourse resource and way of analysing subjectivity but that, at the same time, this means that it is located as a story within that culture. This allows, in terms of this research, for the psychoanalytic concept of containment to be investigated but as a social construction of psychoanalytic discourse in itself.

Existing uses of discursive psychology combined with psychoanalysis seem to have rested on a division between Lacanian and Kleinian views of psychoanalysis apart perhaps from the stance taken by Billig (2006). Lacanian approaches have focused more on the symbolic order and Kleinian more on a relational stance. This does not mean though that the approaches are mutually exclusive. A main difficulty of arriving at a method for my research concerned the idea of psychoanalytic key concepts being related to affect or emotion.

Wetherell (2012, 2013) has taken up this issue and considered whether emotions form part of social constructionism. She describes (Wetherell, 2013, p. 349) how affect has been treated by many as beyond, below and past discourse.

Wetherell defines the impasse:

For some leading affect theorists, such as Massumi (2002) and Thrift (2004 and 2008), the reaction against discourse studies is more far-reaching than a simple, strategic decision to hold discourse (semiotics, studies of talk and text) in abeyance while new methods are initiated and canvassed. Massumi and Thrift's accounts of the relation between affect and discourse have been extraordinarily influential. They present a kind of mash-up from a range of mostly traditional social psychological and psychobiological sources such as EEG studies and social psychological research on automaticity, and in Thrift's (2004) case adding also elements of Damasio's neuroscience and Darwin's evolutionary theory. Affect is positioned as a kind of 'non-representational' domain (Thrift, 2004) or excess (Massumi, 2002). As Blackman (2012, p. 11) describes, these approaches argue that: 'power works "autonomically", bypassing reason and criticality and seizing the body at the level of neural circuits, the nervous system, the endocrine system or other systems assumed to work independently of cognition'

(Wetherell, 2013, p.151).

She queries how this disconnect between discourse and affect can be resolved. She does not seem to acknowledge that psychoanalytic concepts reflected in discourse as specified by Billig (2006) may have a part to play in solving the difficulty that discourse analysis can have with affect. Psychoanalysis has been concerned with thinking about feeling (Bion, 1962b). She expresses a view in her conclusion that

both affect and discourse should be treated, “Within emergent patterns of situated activity” (Wetherell, 2013, p. 365). This research is an attempt to do this.

3.1.4 Limitations of Discursive Psychology

Willig (2001), as a critical outsider, identified limitations of discursive psychology. In terms of a limitation in focus, she suggested that the focus is on the construction and negotiation (Willig, 2001, p.101) of psychological concepts and processes and that discursive psychology does not address questions about subjectivity. Neither, she stated, did it provide any guidance on how to study internal process, such as thought or self-awareness. More recent work, as shown in the previous section, has attempted to address these limitations.

Discursive psychology also emphasises how participants orientate to stake and interest but assumes that people have a stake and interest in this and are able to manage their position. It does not allow for an account of why they take up a particular stance. In summary Wetherell, who criticises from the position of an insider, (Wetherell, 2013, p.103) notes that discursive psychology is social constructionist, relativist and never complete (Billig, 1997:48) or truth telling.

Wetherell (2013) also lists criticisms of discourse analysis:

Many of the points made by recent critics resonate, too, with the extensive internal debates within discourse studies (for example, Schegloff, 1997; Wetherell, 1998; Billig, 1999), concerning the overly deterministic tendencies

in post-structuralist discourse theory and the tendencies of fine-grain work to refuse to raise its gaze from the transcribed marks on the page.

(Wetherell, 2013, p. 350).

3.1.5 Conclusion: Psychoanalytic Discourse Analysis

Understanding these limitations, it is nevertheless the aim of this research to adopt a psychoanalytic discourse analysis which draws on a discursive psychological approach that includes working with affect.

The main reason for the choice of method is that discourse analysis is concerned with process; how people talk. The investigation of my research is into how people respond to someone diagnosed with a personality disorder and the method follows the investigative approach of the question.

The fact that psychoanalysis and discourse analysis already have a body of work in the writings of Kristeva (1996), Parker (2015), Hollway and Jefferson (2013) and Billig (2006) means that there is a tradition within which my research methodology can be based. My research will use countertransference, reflexivity and a psychoanalytical discursive approach to the analysis of the interviews.

This will make a methodological contribution to the field and produce a particular version of psychoanalytic discourse analysis.

3.1.6 Reflexivity

Reflexivity in qualitative research has developed relatively recently and the term is used to describe a particular kind of reflection that involves using subjectivity in research as an opportunity rather than a problem. The reflexive approach has many versions (Lynch, 2000, p.27) but includes reflection (thinking about something after the event) and reflexivity (immediate, dynamic and continuing self-awareness) (Finlay and Gough, 2003). Elliott, Ryan and Hollway (2012) have emphasised that reflexivity addresses the emotional aspects of the work and encompasses attention to the embodied aspects of communication. Their approach aims to develop the awareness of unspoken prejudice. It reflects a greater awareness of the role of the researcher in the construction of knowledge (Bryman, 2012, p. 394). In terms of quality criteria for discourse analysis reflexivity is described by Georgaca and Avdi, (2012, p.157) as, “The overarching principle of constructionist studies”, and listed as one of the key quality criteria.

Wetherell (2012) identifies, “Affective practice” (2012, p.4) as a way of turning social research towards a process based perspective and notes that several writers have focused on this shift (Adkins and Lury, 2009; Ahmed, 2007/8; Blackman and Venn, 2010 and Davidson, Smith, Bondi and Probyn, 2008). Her approach differs from social psychoanalytic approaches (Hollway and Jefferson, 2013; Frosh, 2008; Redman, 2009), as she thinks that an appeal to the dynamic unconscious is an inadequate ground for social research on affect (Wetherell, 2012, p. 22). Wetherell takes her affective practice approach from Walkerdine (2009, 2010) and affirms that emotion or affect is not an object inside the self as such but is above all a relational pattern (Wetherell, 2012 p. 24). She does though then make the link between social

psychoanalysis and affective transmission and picks up psychoanalytic ideas when they are described in terms of relational subjectivities, such as the ideas of transference and projective identification. Her difficulty and confusion with using a wider spectrum of psychoanalytic theory seems to be around making use of a concept of a non-relational unconscious. She acknowledges that Hollway and Jefferson (2013) and Walkerdine, Lucey and Melody (2001) have used psychoanalytic concepts, such as projective identification and transference and countertransference as a tool for social research, and does not dismiss this approach. Her plea in the end is for patterns and ways of describing waves of feeling without defining them as uncanny. My research, in that way, does follow her ideas and uses the object relations theory of Klein and Bion to give a pattern to reflexivity.

Hollway and Jefferson (2013) acknowledge how clinical psychoanalysis has long ago dropped the idea of scientific objectivity and struggled to examine the distinction between meaningful and non-meaningful interpretations or, in their language, good and bad reflexivity (Hollway and Jefferson, 2013, p. 60). They insist that: "Like everything else, subjectivity too must be checked" (Hollway and Jefferson, 2013, p.62).

One of the difficulties that Hollway and Jefferson identify (2013, p. 73) is that, as social science is still imbued with positivist principles about objectivity, fact and replicable evidence, any work using the principle of unconscious subjectivity gives rise to doubts about the validity of knowledge generated. They state that, unlike clinicians, researchers cannot refer to the promotion of the patient's development as a criterion. However, in this research both my development as researcher, the

development of the idea of containment and the possible development of the institution and its staff are explored and can be used to demonstrate the value of a reflexive research approach.

The emergence of countertransference as a more central subject in psychoanalysis arose with a similar rationale to the way in which social science research has shifted, in that the feelings, thoughts and associations of the therapist or analyst have been conceptualised as an opportunity for understanding rather than a hindrance to the work as Freud (1909) originally had suggested. Money Kyrle (1956) stated: "We now also think of it (countertransference) as having its causes, and effects, in the patient and, therefore, as an indication of something to be analysed in him" (Money Kyrle, 1956, p.360).

Writing itself has also been understood in psychoanalysis as a significant contribution to exploration. This was emphasised by Bion (1967, p.123) talking about writing up sessions as a psychoanalytic realisation and Ogden (2005) quoting Frost: "To tell how it can ... It finds its own name as it goes" (Frost, 1939, p. 777). This is enabling in terms of allowing writing to become another live investigative form that is part of reflexivity. There has also to be a reflexive space to assist with this process for the individual researcher in their own mind and in a wider group.

Alvesson and Skoldberg (2009, p. 310), writing on reflexivity, refer to Van Maanen about reflexive writing from a perspective of management studies and ethnography (1995, p.140-141):

This language-first switch produces a culturally relative version of reality and suggests that perception is as much a product of imagination as imagination is a product of perception. Reality thus emerges from the interplay of imaginative perception and perceptive imagination. Language (and text) provide the symbolic representations required for both the construction and communication of conceptions of reality

(Van Maanen, 1995, pp. 140-141).

3.1.7 Ethnography and Psychoanalytic Discourse Analysis

As stated in the Introduction (Section 1.3, page 19) the setting for this research is that I work within the organisation. I carried out the research as a partially participant observer. All the participants were drawn from within the organisation, I played a part in all the interviews and was known in my professional role as an adult psychoanalytic psychotherapist and as having a certain position within the organisation. Some participants were known to me prior to the interviews and some were not. Some were senior in terms of the organisational hierarchy, some were equal and some were junior. In all these ways this research is ethnographic as defined by Bryman (2012, p.443).

In terms of recent ethnographic research and the methodology employed in this research, Hammersley's paper (2006), "Ethnography: Problems and prospects", states that ethnography and discursive approaches can be used together. They are not seen as incompatible, although some types of ethnography, particularly more traditional anthropological or sociological forms, are seen as being less compatible with a discursive approach.

Smart (2013) uses a method that combines ethnography with discursive psychology and quotes Mercer (2010) stating that ethnographies in more familiar environments are becoming increasingly common and can provide better insights into debates. Hammersley (2006) accepts that the use of ethnography as a standard term for many kinds of research, where the researcher is a participant in the environment that is being researched, is usual.

My position as a researcher researching within my employing organisation can, according to Hammersley (2006), allow this research to be described as being within an ethnographic framework. The discursive analysis of this research takes place in this context.

3.1.8 Use of a single case assessment as the basis for open interviews

I chose to use my own psychotherapy assessment of a single case as a basis for all the interviews (see Appendix J). The approach enabled me to use a combination of observation, countertransference reflection and reflexivity in monitoring my own and others responses to an identical written report of an assessment that I had undertaken.

The single case has provided the base for psychoanalytic research since Freud. Single cases have also been categorised (Harris, Helfand, Woolf, Lohr, Mulrow, Teutsch and Atkins 2001, p.26) as in the lowest category on the hierarchy of quality standards for the U.S. Preventive Service Task Force. They were also considered by NICE (2009) as the least valid form of evidence with regard to treatment effectiveness. However, recently there has been some resurgence of interest in the

single case. For example: Helleman, Goossens, and Van Achterberg (2016), Artaloytia (2015) and Gottdiener and Suh (2012). Gottdiener and Suh (2012) propose a research strategy for psychoanalysis based on single cases.

Hinshelwood argues (2013, p.71), taking models from the natural sciences, that single cases can test psychoanalytic theories providing that there is attention to research design. He states that there needs to be a binary question such as, if a dream interpretation is made are the symptoms alleviated? This can then be proven or not. He sees this as reducing the variables and making the outcome of single case study research more reliable. He also sees research in a positivist frame. Although Hinshelwood argues for the inclusion of hermeneutics within a positivist research model, in the example he gives of testing the theory of envy (Hinshelwood, 2013, p.178), he relies on the idea that change is produced by the content of what is said, rather than on the change in his countertransference and his understanding of the patient. Although stating that he relies on hermeneutics, it seems as if, in this case, he is relying more on verbal content than interpretation for the result and less on his countertransference. He may not, although making use of countertransference, be putting it at the heart of his research, as Lorenzer (1986), Oevermann (1993) and Midgely (2006) suggest.

I use a single case, my written psychotherapy assessment of one person for several reasons. It allowed for a control of variance as each interviewee was presented with the same material. It allowed me to explore the material and to reflect on my own countertransference in relation to the assessment and each interview without the added complications of a larger and inevitably more varied sample. It was important

for me that the assessment was one that I had both undertaken and written, as this enabled me to use my own direct countertransference response to the case, as well as my experience from the interviews. This enhanced my reflexivity throughout the research and in the writing up. The argument for a single case study included the idea that it allowed for a greater depth of investigation. The single case was selected according to a sampling procedure described in Section 3.4 (page 104).

3.2 Standards for Qualitative Analysis

Several different ways of assessing the quality of qualitative research have been described by different researchers. It is commonly accepted that objectivity or lack of bias is not a valid criterion for judging qualitative research. As Wiggins and Hepburn (2007) state: "As this work is completely different from the factors and outcomes approach that is characteristic of much mainstream social psychology and sociology it does not lie well with input/output style evaluations" (Wiggins and Hepburn, 2007, p. 281).

Qualitative research has developed different ways of assessing quality and these have related to different types of qualitative work. For instance, Henwood and Pidgeon (1992) produced guidelines for assessing quality in grounded theory and Elliott, Fischer and Rennie (1999) suggested a number of criteria, which are applicable to both quantitative and qualitative research. These were appropriateness of methods, clarity of presentation, and contribution to knowledge. Working within a phenomenological hermeneutic tradition, they saw qualitative research as requiring further attributes: owning one's own perspective, situating the sample, grounding in

examples, providing credibility checks, coherence, accomplishing general versus specific research tasks and resonating with readers. As Willig (2001, p.144) states neither of these guidelines for quality assessment are specific to a discourse tradition.

In order to evaluate this research in a meaningful way there needs to be a relevance to the methodological approach. In a paper by Dewulf, Francois, Bouwen and Taillieu (2006) approaches by both Wood and Kroger (2000) and Antaki, Billig, Edwards and Potter (2003) to quality in discourse analysis are described.

Wood and Kroger (2000) propose a series of quality criteria designed to ensure quality in discourse analysis grouped under the headings of trustworthiness and soundness. Trustworthiness refers to the systematic and thorough way in which claims are arrived at, while soundness refers to the solidity and credibility of those claims.

For trustworthiness the following criteria are proposed: orderliness and documentation in terms of the clarity of the way in which the research in all its aspects was conducted, recorded and reported, so as to provide a context for understanding the claims; and audits and to permit external researchers to examine the processes whereby the data were collected and analysed.

For soundness the following criteria are proposed: demonstration, to show the argument through presenting the steps involved in the analysis of extracts rather than simply telling the reader about the argument; coherence of the set of analytical claims made about the discourse; plausibility in the sense of whether or not a set of claims is acceptable in the light of previous research and fruitfulness in terms of the

scope of analytic schemes to make sense of new kinds of discourse and to generate novel explanations.

As Dewulf, et al. (2006) state:

These criteria guarantee that the different steps in the research, from data gathering to the final analytic results are as transparent as possible, allowing the reader to evaluate the line of argument leading to the analytical results, and if necessary indicate at which point another line of argument could be pursued (that might be more coherent, plausible or fruitful)

(Dewulf, et al., 2006, p. 12).

Wood & Kroger (2000) argue that demonstration and fruitfulness are among the most crucial criteria.

Antaki, et al. (2003) discuss quality in discourse analysis from the perspective of a critique, describing six types of analytic shortcomings. They identify the following ways of treating discourse as falling short of discourse analysis: under-analysis through summary; under-analysis through taking sides; under-analysis through over-quotation or isolated quotation; the circular discovery of discourses and mental constructs; under-analysis through false survey; and under-analysis through spotting. They do not therefore define one right way to do discourse analysis. They are intent on allowing a maximum variety of directions to develop. They do state that: "Perhaps it is safe to say that analysis means a close engagement with one's text or transcripts, and the illumination of their meaning and significance through insightful and technically sophisticated work. As they put it, "Discourse Analysis means Doing Analysis" (Antaki et al. 2003: 10).

Willig (2001) summarises quality in discursive psychology as the accounts produced being best evaluated as discursive constructions in their own right: "Do they tell a good story? Do they tell a story which is clear, internally coherent and sufficiently differentiated? Does it generate new insights for readers? Is it convincing?" (Willig, 2001, p. 148). The emphasis is on quality rather than validity and yet, as Madill, Jordan and Shirley (2000) pointed out, this does not mean that any interpretation is as good as another.

For my research the Wood and Kroger (2000) quality criteria will be used. In addition to quality assessment criteria for discursive psychology, they give scope, under the heading of fruitfulness, for the use of reflexivity and a psychoanalytic approach. As Alvesson and Kärreman (2000) point out: "To describe the language use in a specific interaction ... in some detail, is certainly not unproblematic, but may still be a more rigorous enterprise than any attempt to study people's beliefs about the world or their actions. A relatively high degree of 'empirical accuracy' may be said to characterize this sort of research." (Alvesson and Karreman, 2000, p. 22).

3.2.1 Validity

Validity in discourse analysis, as Wetherell (2001) states, is a complex concept which includes ideas of coherence, the generation of novel ideas and findings, plausibility and the grounding in previous research.

In this research the principles of soundness and trustworthiness as identified by Wood and Kroger (2000) will be applied. Consideration will also be given to deviant case analysis in order to check for exceptions or counter instances.

A series of consultations with a peer group in addition to regular participation in a learning set and regular supervision was used to ensure coherence of method and the validity of analysis (trustworthiness and soundness) during the period of the research. Reflective notes from these sessions form part of the reflections on the research as a whole.

3.3 Ethical Considerations and Procedures

The research took place in an NHS context and NHS ethical approval was sought for the research in addition to the University of Exeter ethical approval. The primary ethical concern was for the participants. This meant the one person whose assessment would be used for the interviews and the staff who participated in the interviews.

My approach to ethics included the idea that ethics are emergent and form part of the reflexive process. Ethical issues are included in Chapter 6 on Reflexivity and in the Discussion and Conclusions (Chapters 7 and 8). This view of ethics reflects the ideas of Griffin (2002) that ethical responsibility is not just located in the system but also in the individual.

Explicit informed written consent was sought from both the person whose assessment was used and the members of staff concerned. Two information sheets were prepared according to NHS guidelines for use with all participants (see Appendix K). One information sheet was for the person whose assessment would be used and the other was for the staff. In the case of the person whose assessment

was used the information sheet was presented to the person and a family member by the researcher and an opportunity to question the research was given. The information sheet included an explanation that the material would be anonymised and that no identifying details would be released into the final report or the public domain. The person whose assessment was used was invited to discuss the information sheet and to sign the consent form (see Appendix L). In view of the personal nature of the detailed disclosures made in the assessment and in a later written statement by this participant it was decided, after consideration with others, to edit the assessment and written statement in the appendices of this thesis (Appendices J and Q) before publication on open access.

In the case of staff, the same procedure of discussing the information sheet and giving written consent was carried out at the interview stage. The information sheet and consent form were circulated to each participant prior to the interview and an opportunity to question the research was given at the beginning of the interview (Appendices, K, L and M). The declaration of consent to the material being used for research purposes included a statement about anonymity and there was a further statement that no individual would be identified in the final report or details of any individual released into the public domain. There was also a statement in the information sheet that the material in the assessment may be upsetting or disturbing and that there would be the opportunity to de-brief and talk through any issues. Time was allowed for this following the interview and in addition contact details for the researcher were given to staff participating should they wish to talk any issues through at a later date. It was made clear at the beginning of the interviews that staff could terminate the interview at any time.

I made an ethical distinction between psychoanalytic interpretations that would not be made in the interviews and the use of psychoanalytic constructs in the analysis of the data. The use of psychoanalytic interpretation has been seen as a contentious issue (Hollway, 2015, p.101). However, Frosh and Emerson (2005) argue that all interpretation relies on some theoretical construct, whether the approach to the data is inductive or deductive. Psychoanalytic writers such as Gabbard (2000) focus the ethical debate on interpretation and confidentiality in psychoanalysis on clinical work in the consulting room. The research context where people are asked for informed consent for research interviews is very different to this. The consent process described on page 103 made clear that there would be analysis of the interviews. In this context I decided, following discussion in the learning set, that using the theoretical constructs of psychoanalysis in the analysis would be ethical.

Data and transcripts were anonymised and stored on a password-protected device. Only anonymised data was used in computer software or manual analysis.

The researcher treated information gained from the assessment and the interviews as confidential in line with NHS and the British Psychoanalytic Council guidelines. Maintaining confidentiality meant that transcripts or other material can never be linked to an individual. The decision to edit Appendices J and Q prior to publication reflects these guidelines (see page 102). Any essential record of names of staff involved in the research was destroyed after the interview had taken place and a code given to identify the material. The location used for the interviews was one where confidentiality is respected and will be guaranteed.

The ethical approval letters from the NHS Ethics Committee and the University of Exeter are to be found in Appendix N.

3.4 Sampling

3.4.1 Selection of the single case

Although the selection of the single case had to be convenience based in terms of fitting the timescale of the research, it was in one sense also random in that the psychotherapy assessment used was taken from a group of assessments done during a particular month. These assessments formed part of the normal work of the service in terms of assessments being made of referrals to the specialist unit (see Section 1.3, page 17). No other selection criteria, apart from the assessments happening at this time, would be used initially. The assessments for consideration for the research were taken from a point in time only.

Scarfone (2011, p. 758-9) states that the criteria for an assessment are that it is:

- a trial of ideas;
- a lively experience to read;
- an invitation to take an active part in in the exploration;
- a live wire connection.

The phrase 'a live wire connection' is used by Scarfone in this paper to imply that the, "Act of reporting has to stay actively linked to the living experience of the analysis" (Scarfone, 2011, p.759). He explains that the live wire connection means that the act of reporting in writing is a continuation of analysis in another form.

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Blass (2013) in a paper introducing others writing about the presentation of case material emphasises contextualising and avoiding any idea of objectivity.

Chabert (2013) asks if case material is an open ended dialogue that puts you in touch with what went on in the session and asks if it expands associative thinking.

In addition, criteria for an assessment for the local unit where the research was based included an adequate history, an account of risk and a psychodynamic formulation.

Scarfone (2011), Blass (2013) and Chabert's (2013) criteria were used in addition to the local criteria for the assessment. In order to ensure that these criteria were met the three assessments done during the research period were taken to an assessment workshop for consideration. In addition to myself this workshop was composed of the Consultant Medical Psychotherapist, an Adult Psychotherapist and a Senior Registrar.

The single assessment was written in the usual format of background and history, an account of the assessment sessions including reflections of the assessor and a formulation and summary section. The decision was to follow usual practice in terms of what an assessment would include and all sections were used in the interview process. I undertook the assessment myself and this was a purposive choice as it allowed for the use of my countertransference reaction to the person concerned to be as immediate and lively as possible. As stated earlier in Section 3.1. 8, (page 96) a copy of the assessment used as a basis for all the interviews is to be found in Appendix J.

Ethical permissions were sought from the people assessed. Having informed consent dictated which assessment could be used for the research.

3.4.2 Selection of Participants for Interviews

The interviews were based on the reading of the assessment report by participating staff. The selection of the staff participants was purposive in that people selected had a direct link to the research questions in terms of working in some way with people with a diagnosis of personality disorder and working within the NHS Trust that was the focus of the research.

I was researching the psychoanalytic containment provided by staff with an underlying question about the concept of containment and whether or not it was utilised, understood or formed part of the organisational culture. Because of this, interviewees were selected to form a maximum variation sample of staff, which aimed to show diversity in responses including those that were less usual. The aim was to recruit participants from board to floor, a slice across the hierarchy, who could show different perspectives. Consideration was also given to having a sufficient gender balance and ethnic mix to reflect an approximation to the Trust workforce. The plan was to do twenty interviews during a six-month period as this would provide sufficient information from a variety of members of the organisation. In the end twenty-one interviews were carried out.

3.4.3 Recruitment of Participants

With consultation with a supervisor who was also an organisational consultant within the Trust a long list of 35 people from as wide a range of professions as possible was drawn up. This list included cleaners, managers, clinicians, the chief executive and senior consultants. These people were then approached about participation by email or personal contact. An example email is included at Appendix O. There were 21 positive responses and these people were all interviewed.

3.5 Interview Structure and Technique

The interview was structured to encourage as much free association as possible from participants (see Appendix M); the aim being to capture participants' free associations to the assessment of the particular case and then to engage in some open dialogue about the case and their response to it. The use of open dialogue, rather than any semi structured or structured interview plan, was to enable the interviews to be iterative and developmental. The method of interviewing followed psychoanalytic principles, in that in addition to allowing for free association, it allowed for associations and a dialogue that is not constrained by direct questioning. Neither I, nor the participant, would be subject to pre-planned questions or topics of response.

In order to enable participants to feel sufficiently at ease to give their own associations, I read aloud the background and history of the case as taken from the Trust's records at the start of each interview. This was timed to take approximately ten minutes. I then gave the record of the assessment sessions to the participants to

read to themselves. Then I switched on the recorder and people were asked to talk freely. My intention was to leave participants to talk without intervention for as long as possible. At the end of the interview the recorder was switched off and time was allowed for participants to comment without the recorder and/or to ask for any debriefing they might feel they needed. Participants were asked if they wished to hear my formulation and summary of the assessment and, if they asked to hear this, I read this to them. The time allowed for the whole process was one hour (see Interview Schedule, Appendix M).

Immediately following each interview, I wrote a memo of reflections on the interview. These included notes on comments made after the recorder had been switched off or before it had been turned on.

3.6 Reflexive Practice

As described in Section 3.1.6 (page 92) reflexive practice was key to the research. My reflexive practice included a focus on countertransference. This was built into the research design of the data collection in the following ways.

The criteria for the selection of the single assessment were considered in the Learning Set, which included my first supervisor and two other doctoral students. The criteria were tested and jointly agreed. The assessment of the single case was taken to an assessment workshop, where the experience of the assessment, the write up and the formulation and summary were thought about and agreed by the group. The outcome for the person assessed was also agreed in this group. Ethical

issues about gaining informed consent and future contact with the assessed person were also considered.

With regard to the selection and recruitment of participants for the interviews there was discussion with supervisors to identify barriers to recruitment and to reflect on the interviews themselves. A psychoanalytic supervisor was also used for my personal supervision. This supervision and reflexive process continued in the Learning Set, which met regularly during the research period.

A reflexive group which I was part of was run as part of the doctoral programme and I also participated in a group for Trust staff which ran alongside the research.

The reflective memos written following each interview were linked to the individual interviews and used in the data analysis.

A reflective log was kept throughout the research process.

3.7 Method of Data Analysis

3.7.1 Design of the discourse analysis

The overall plan for the discourse analysis allowed for an iterative process. I selected analysis of **positioning** (see Section 3.7.3, page 113 and Section 4.1.1, page 119) as the first step as this was a way of investigating how people positioned themselves in relation to the assessment material and how they positioned themselves in relation to me in the interview. The use of an analysis of positioning of self or selves was

chosen as a way of investigating and analysing the process of containment (see Figure1, Section 1.8, page 34) and demonstrating people's approach in terms of how much containment was being shown in the interviews. I did this by exploring the positions and sub positions of 'I', 'You', 'We' and 'They'. The position of reflecting 'I' being the closest to containment as defined for the purpose of this research.

I also chose to investigate the **stance** (see Section 3.7.3, page 111 and Section 4.1.2, page 119) taken with regard to the concepts: death, suicide and self-harm and containment. Investigating the stance taken was chosen so that defensive positions towards these concepts could be identified. I also considered a common **discourse marker** (see Section 3.7.3, page 111 and Section 4.1.4, page 121) which reflected positioning in relation to me as the interviewer. I looked for overt use of **intertextuality** (see Section 3.7.3, page 111 and Section 4.1.3, page 120) as another way of avoiding direct emotional contact with the material and instead identifying with theoretical models, the institution and professionalism or role. This was followed by an analysis which looked specifically for particular psychoanalytic primitive **defences** (see Chapter 5, page 157) in the interviews. I made use of the audio recordings, transcriptions and my own field notes for the analysis.

I used the steps outlined by Wiggins and Potter (2008) for discursive psychology to analyse the interviews: **transcription, coding, analysis and application**. These form the four last steps of their seven step approach to discursive analysis (see Appendix P) but, as they comment, there are no hard and fast rules for this type of research. However, structure enables a certain transparency and quality criteria to be applied.

The quality criteria used are those of Wood and Kruger (2000) as identified in Section 3.2 (pages 97-100).

One of the features that distinguishes my research from many others is that I was inviting people to speak about a piece of text. The text of the assessment that people read was identical for all the interviews. In this way the interviews do not constitute a normal discursive approach, which would be an investigation of naturally occurring talk. There is a period of free association monologue in all the interviews.

3.7.2 Transcription, audio recordings and field notes

Interviews, with the exception of one in which the recorder failed, were audio recorded. The interviews were transcribed using a full verbatim transcription. The transcription included ums, ers, you knows, repetitions, etc., and is an exact reflection of every spoken word. Ellipses are used where necessary [...], i.e. when a speaker changes direction. [Laughter] [Pause] [Overspeaking] and unclears with the relevant time codes are also included in the transcript. This was not identical to a Jefferson (2004) transcript. In particular, there were no intonation (louder or softer) markings and this is one reason why the transcripts were used alongside audio recordings. The audio recordings of the interviews were used in parallel with the transcriptions to give depth to the analysis.

3.7.3 Coding

The coding stage was the preliminary stage of the analysis and was done in a way that was as inclusive as possible. A full list of the codes used is to be found in Tables 2 and 3 in this section (pages 113 and 114).

The codings were based on a discursive approach to the research questions taken at two levels as described in Section 3.7.1 (page 110). For the purpose of my research the concepts of death, suicide, self-harm and containment are defined as social constructions that have, as described in Section 3.1.2 (page 112) by Parker (1997b, p.227), a more enduring and broader based quality. The concept of death has a wide cultural construction and containment a psychoanalytic one, in addition to a more general medical and cultural construction.

Computer based software, NVivo, was used for an initial coding of the data. Bazely (2007) points out that being distanced from the data could be an outcome of the use of a computer software system and mean reneging on the effort of reading, listening to and writing about the interviews. However, coding was used as an initial stage and close reading and listening to the audio recordings was then carried out. Validating the coding was done with a group of colleagues checking ten per cent of the material (two interviews). Using computer software meant that textual transcriptions, audio recordings and field notes could be worked with simultaneously.

The initial coding analysis focused on subject positions or number of selves. Each interview was searched according to the use of 'I', 'you', 'he', 'she', 'it', 'we' and 'they' with subsections, which would help to identify the position of the subject. These are shown in full in Table 2 (page 113). For example, 'they' was coded as either: they, others; they, service users or they, staff. The analysis of numbers of selves was used as a way of linking text to the concept of positioning. Positioning was used as a basis for further analysis and thinking about the defences and projections that were

active in the interviews. **Positioning** is explained in more detail in Section 4.1.1 (page 118).

Table 2: Coding Categories for the Positioning of Selves

Positions of selves	Detail of position
I	Depersonalised Reacting Reflecting
You	Identifying with interviewer The interviewer Depersonalised or generalised
He, she, it	She as the case subject She, he, other
We	Interviewer and interviewee Professionals Wider institution and organisation General, anyone
They	Staff Others Patients, service users

Further coding was carried out using two key concepts: containment as one concept and death, suicide and self-harming as another (see Table 3, page 115). These were subdivided into stances taken towards the concept: direct references, implied, dreaming, physical, opposite and omission. This mapped how the concepts of

containment and death were spoken about in the interviews as a basis for further analysis. Stance taking is described by Lampropoulou and Myers (2013) as:

Shifts are often framed in terms of stance taking, focusing on the triangle of relations between the interviewer, interviewee, and object of the stance. For instance, the interviewee may shift the terms by rewording, or challenge presuppositions in the projected stance, or give their own stance only indirectly by giving someone else's stance

(Lampropoulou and Myers, 2013. Art.12).

Stance is discussed in more detail in Section 4.1.2 (page 119).

Table 3: Coding of Stances Taken towards Death and Containment

Concept	Stance Taken
Containment	Direct reference Dreaming Implied Physical Opposite
Death, suicide and self-harming	Direct reference Implied Omission

Several reports were run on NVivo to identify text where more than one code had been applied. For example, the positioning of self code, 'Reflecting self' was run with the coding of, 'Implied containment'. This gave the positioning and stance when linked to an idea of containment. An example of part of a report of a coding matrix is given in Appendix R.

Frequently used phrases known as **discourse markers** (see Section 4.1.4, page 121) were searched through all the interviews using NVivo. This was a normative search for common phrases within the interviews.

Categories of employment were given to each interviewee. Six categories were used: administrative/clerical; middle management; clinician; senior clinician including consultant psychiatrist, psychologist and psychotherapist; senior management and Board member.

3.7.4 Analysis

Discourse analysis has no wide agreement about the process of doing the analysis (Georgaca and Avdi, 2012). Although this research follows the guidelines of Wiggins and Potter (2008), there is still some variation about the focus of the analysis, as is normal in discourse analysis. Georgaca and Avdi (2012, p. 151) refer to several inter-related levels of discourse analysis.

I chose to investigate the interviews by looking at positions and stances in the discourse first. I chose analysing **positioning** (see Section 4.1.1, page 118) in the discourse as a way of investigating positioning of the self which avoided or not a

reflecting 'I'. In the context of my research I was particularly interested in any avoidance of the position of the reflecting 'I' as in the psychoanalytic definition of containment, the reflecting 'I' is a necessary part of the process (see Figure 1, Section, 1.8, page 34). This reflecting 'I' shows an internal representation of feeling and disturbance demonstrating the third level (iii) of Figure 1, being able to symbolise feelings.

I also chose to use the concept of **stance** (see Section 4.1.2, page 119) as a way of identifying stances taken towards the concepts of death, self-harm and containment. The stance taken giving information about how people related to the concepts and whether or not they addressed them directly. As a further way of identifying distancing and defensiveness I looked at **intertextuality** (see Section 4.1.3, page 120) in the text to give an idea of other discourses people resorted to in this context.

Finally, I chose to look at specific primitive psychoanalytically defined **defences** (see Chapter 5, page 156) which were present in the interviews.

Analysis: Positioning, Stance and Intertextuality

4.1 Introduction

This chapter is concerned with the analysis of the interviews in terms of positioning, stance and the intertextuality used. It is structured in response to the two research questions:

1b) How do staff talk about suicide, annihilation and death?

1a) How do staff talk about themselves in relation to the assessment?

The third research question, 1c): “How are psychoanalytically defined defences employed to work against the idea of containment?” is addressed in the next chapter.

The remaining two research questions, 2 and 3, concerning reflexivity and future developments for the organisation are answered in the discussion and conclusion. The answer to the overall question, 1: “What psychoanalytic containment do staff of the institution provide for a person diagnosed with personality disorder?” is considered in the conclusion.

The analysis in this chapter concentrates on how people talked in relation to the research questions in terms of subject **positioning**, **stance** and **intertextuality**. I also paid attention to one **discourse marker**, ‘You know’, which stood out from the

transcriptions as the most commonly used in some of the interviews. These terms are defined in the following sections (4.1.1, 4.1.2, 4.1.3 and 4.1.4). An example of an excerpt of an interview is to be found in Appendix Q and a sample of an excerpt of a matrix coding report linking two codes (see Section 3.7.3, page 111) is to be found in Appendix R.

4.1.1 Subject Positioning

Discourse analysis involves looking at shifts in positioning (Davies and Harre, 1990, Drewery, 2005, Harre and Van Langenhove, 1999, Harre and Moghaddam, 2014). **Positioning** asks questions, “Who speaks? In whose name do they speak? Who do they address? Who do they speak for?” (Georgaca and Avdi, 2012 p. 155).

In their chapter on positioning theory Harre and Moghaddam (2014) state, “Persons ‘have’ selves,” (Harre and Moghaddam, 2014, p.132). They categorise these selves as embodied, autobiographical and social acknowledging that all three types have multiple selves. My research touches on all three aspects of ‘selves’ as described by Harre and Moghaddam (2014). They explained these as: embodied as in the definition of a life or professional position; autobiographical as in the definition of a reflecting ‘I’ and in attribution to a past or future self and social in the sense of selves defined in a position, primarily related to the interview situation. Positions are also described as labile, temporary and debatable. Positions are also discussed by Hollway (2014, p.141) in terms of a question about how positions may link to a person’s sense of agency. This is relevant to the strand of psychoanalytic thinking about the process of containment referred to in Chapter 1, Introduction and to Knox’s (2009) paper concerning the development of a sense of agency. In terms of the

categorisation of selves that I have used, the reflecting 'I' links to the sense of agency. Table 2 (page 113) shows the analysis of selves used with the text of the interviews.

The definition of positioning I use is close to that of Moghaddam and Harre (2010).

Positioning is about how people use words to locate their sense of self or selves.

4.1.2 Stance

Stance taking, defined by Du Bois (2007), is composed of evaluating, positioning and aligning (Du Bois, 2007, p.164). He describes a stance triangle of the first object, the second object and the (shared) stance object. Stance taking is a broad term encompassing a range of linguistic features such as modality, evaluation, politeness or metadiscourse (Myers, 2010). It has emerged since the mid-eighties from different fields, such as linguistics, sociolinguistics, linguistic anthropology and conversation analysis (Haddington, 2004). In the sense of the linguistic origins stance taking has a potential relevance to discourse analysis. Baynham (2011) writes about stance-taking and discursive positioning by investigating stance, positioning and alignment in professional experience. Du Bois claims that stance is a shared intersubjective activity accomplished in interaction (Du Bois, 2007). It is dynamic, dialogic and intersubjective.

I use stance taking to look at how people assign value to and align themselves or not towards concepts: suicide, death and self-harm and containment. This is a specific use of one aspect of **stance**. Conversation analysis has used the concept of stance in looking at actions (Haddington, 2004). Here I am using the idea of **stance** in relation to how a subject evaluates a concept (Du Bois, 2007). This enables me to identify whether or not people take a reflective and containing approach to the

concepts themselves and to explore how they may avoid them.

The terms **stance** and **positioning** overlap in Du Bois definition (2007) as the stance triangle is described as involving positions in respect of the subjects and objects. The notion of alignment is also present in the Du Bois triangle (2007). Here I have used the concepts of **stance** and **positioning** to distinguish the way I have investigated the **positioning** of self or selves in the interviews generally and the investigation of an approach or **stance** in relation to a concept.

4.1.3 Intertextuality

Discourse utilises other texts and words that have been used in other contexts and come from other origins (Lemke, 1992). Such references may be explicitly taken from other texts or they may refer to other past or future texts. Lemke (1995, p.23) argues that we, “Make sense of every word, every utterance, or act against the background of other words”. Every text is ‘intertextual’ in relation to other texts. As was described in 3.1.2 this approach has origins in the work of Bakhtin (1981) and Kristeva (1998). Kristeva did not see intertextuality as linked only to a simple idea of citations but about showing how much the text is indebted to its outside (Kristeva, 1998). It is a broad concept and as Allen (2011) states one that has been re-named many times (Allen, 2011, p. 214).

In my analysis of the interviews for the purposes of answering the research questions, I restrict the use of **intertextuality** to citations and references to other discourses. This is a limited definition of intertextuality but one that allows for identification of key other texts that are used in response to the assessment material. It also links with the analysis of positioning and stance taking to inform the analysis

of how people may avoid containment and to give an idea of the defensive manoeuvres used.

4.1.4 Discourse markers

Phrases like, “You know”, are frequent in talk. Researchers have not agreed on what purpose they fulfil (Fox Tree and Schrock, 2002). Some have argued that they are negotiating strategies (Jucker and Ziv, 1998). Fox Tree and Schrock (2002) argue that **discourse markers** may be multi-functional. I have chosen to look at one common discourse marker in the interviews in relational terms.

4.2 How do staff talk about suicide, annihilation and death?

4.2.1 Containing at a distance

This section explores the avoidance of containing the ideas of suicide annihilation and death in the interviews. Not everyone mentioned death, suicide or risk, although this topic was mentioned in the assessment. Of those that did, there were people who took the stance of being someone who could think about the concept and the process needed to deal with the communication of suicidal ideas. This, in the interview quoted below, included the implied use of the psychoanalytic theoretical construct of containment, which had been absorbed and could be made use of in the interview and with this group of patients. The interviewee knew how, by implication, to treat the, “Patient who only wants to be dead”, with the use of a containing other mind:

I think mostly, even the most suicidal, hopeless at the far end of despair patient who only wants to be dead is in that state trying to communicate something and they need another person to participate with this dance, which is why they engage with mental health services and why they, er, tell people of their suicide plans. It's not that they don't intend to carry it through. It's not that they are manipulating people. It's that, er, it's that for very severely disturbed narcissistic patients they simply cannot manage their own states of mind in one mind. They need two

(Interview 10: Senior Clinician, Female).

The stance of this interviewee as understanding (not necessarily providing) the potential second mind implies that they may be using psychoanalytic concepts in their discourse. "Very severely disturbed narcissistic patients they simply cannot manage their own states of mind in one mind". Several aspects of Bion's concept of containment are present in the statement. Bion's (1962a) concept of projection and modification of infantile fears needing to be a two-person process is stated but not referenced. "They need another person to participate with this dance, which is why they engage with mental health services". Also implied in the text is that another adult, rather than the primary carer of an infant, can provide this function. This is evidenced in the use of the term, "Mental health services," and, "They need two". The interviewee is positioned as a theoretician, saying that they "think", and stating certainties such as, "It's not that they are manipulating people," as they talk. This is not presented as a single person's view but as a statement of knowledge. There is one qualification of, "Mostly," right at the beginning of the excerpt which allows for the possibilities of other perspectives but the rest of the passage gives little scope for

anything except a position of the interviewee, and possibly the interviewer, being the one or ones who know. The type of knowledge and the theory could be identified as intertextual and psychoanalytic as it relates to the theoretical writings of Bion and the position of the interviewee as one of a psychoanalytic practitioner.

This interviewee positioned themselves as distant from the patient in the assessment using 'they' frequently. When talking about suicidality and death in this interview, as in the extract above, the terms, "Patients", or, "They", were used, although in other parts of the interview they referred directly to the person of the single case. This suggests that in relation to death the interviewee is positioning herself at a distance. The interviewee refers to theory and de-personalises the case. This could be understood to show a distancing or defensiveness about suicide and death and could raise a question about whether theory is essential to this person as a structure within which they can respond to suicide, or other concepts that they found emotionally difficult. In this sense the interviewee herself is not acting as a container in the sense that Bion (1962a) describes, which implies the projection of infantile feelings, which are received by the other. The process is being described using a particular stance of the theoretician or one who knows. This interview relates to the concepts but not in the first person or often directly in relation to the subject of the assessment.

Interviewees frequently took up a stance themselves, or as others rather than as themselves, wanting to get rid of the problem of suicide and death:

I did hear a comment by some person who said...I won't mention any...Well, you know, I just wouldn't admit them to the ward and we'd just have to take the risk and if they kill themselves, they kill themselves. And that was from a very senior person, you know, erm, and I think that's really sad, you know

(Interview 11: Clinician, Male).

In this excerpt the interviewee is hesitant about the distancing: "I did hear a comment by some person who said...I won't mention any ...Well, you know". This is as if a feeling is preventing directness. The projection onto others is perhaps acknowledged as in some way shameful in the hesitancy of, "I won't mention any...Well, you know", or as a betrayal of a different perspective which may be held by the interviewee themselves. This different perspective is associated by this interviewee with feeling, "Sad". There is also the reference to a, "Very senior person", positioning the interviewee as less powerful than the other and giving responsibility for the dismissal of people who want to kill themselves to someone at a higher level in the hierarchy and perhaps therefore more identified with an alien aspect of the institutional culture.

There was in some interviews a disowning of any personal feelings that could influence a decision:

I mean, we've always admitted people with these, kind of, difficulties to wards, because we can't help ourselves, and society requires that we do it

(Interview 13: Board member, Male).

Here the interviewee positioned themselves as, “We”, and as a professional, perhaps in relation to the researcher, but perhaps more in relation to his own professional grouping which was different to that of the researcher. “We”, he seemed to say, is nothing to do with personal feelings, “We can’t help ourselves”. This portrays a self without identity except as a professional and any sense of self is subject to his position. The position has power but it is not identified as being related to an emotional sense of self in any way other than as a professional.

The stance of a collective sense of professionalism and of acting in a role rather than in any position of self-reflection is attributed to fear in another interview, “It’s fear of somebody really killing themselves”:

The reason why women like this end up on wards is because of fear of risk. It’s a fear of somebody really killing themselves, and the blame culture that’s associated with that. Erm, and that’s why they end up being contained for their own safety, where I actually think it’s for the...I think people do...therapists...well, not therapists. What can I say? Healthcare professionals do it to protect themselves

(Interview 18: Senior Clinician, Female).

The interviewee hesitates: “Where I actually think it’s for the...I think people do...therapists...well, not therapists. What can I say? Healthcare professionals do it to protect themselves”. The hesitation, perhaps reflecting and remembering that I, the interviewer, am a therapist. To avoid being positioned in opposition to me as a therapist the interviewee then encompasses everyone by using the term, “Healthcare

professionals". There seems to be an implication that, "We", need to avoid fear and blame. This would position everyone in a place where difficult feelings are mainly avoided. It is a stance positioned in opposition to a psychoanalytic view of containment, where feelings that are projected need to be processed by another. It raises a question, which will be taken up in the discussion, about whether, from a psychoanalytic perspective, the organisation is doing harm by rejecting the emotions and, "Protecting themselves", which would lead to further enactment by patients. Questions are also raised by the implication that fear and blame are key motivators for staff. This, in psychoanalytic terms, means that staff are operating in a paranoid schizoid position rather than a depressive position with consequent re-enactments and action by both staff and patients rather than any processing of feelings.

In this interview there is also a gender specific comment in, "Women like this". The interviewee was female. There is a link made between the problem of suicidal risk and gender. A question is raised about gender by this link in that suicide is not linked to males. How much suicide is an expression of murderous rage in relation to any sense of gender related disempowerment is a question which I will not investigate fully. However, this could relate to psychoanalytic ideas of a bad object being projected and then re-introjected as something powerful and destructive. This may have relevance to the way in which the organisation can act as an assertion of a type of male authority, which rejects rather than investigates and processes murderous feelings.

The distancing from and avoidance of containing suicide and death take several forms in the interviews as shown in this section. Immediate personal disturbance is

avoided by the use of knowledge and theory, depersonalisation, a distancing of self from others and the location of opinions in others. There is also a disowning of personal feelings and a retreat to collective professionalism or other grouping.

4.2.2 Reflecting on emotions

This section identifies how people reflected on emotions and, in particular, how they made use of a reflective 'I'. The reflecting 'I' is taken as the closest to the position of psychoanalytic containment as it implies an internal reflective process when it concerns reflecting on emotions or disturbance. Other ways in which people positioned themselves in relation to emotions and their own disturbance or that of others are also described.

The personally reflective stance was taken in some interviews, the language was direct in the use of 'I' and 'her', referring to the case of the single patient in the assessment.

In order to face the hardness of the narrative or the experience, because thinking on the artery and cutting, I think that if I am oblivious to her...and I'm not sure that it is...er, it could be...and this is the hard part, I think, that it could be experienced as if it's done to me what she does to her. So if I...I, fear that if I am, if I am oblivious to her cutting, she will cut deeper so that I am not blinded to it...and it could go very deep, and it might go as deep as it needs to go, and that could include the artery. And I'm not sure...so, so that...So how, how far could I...? How blind could I be to her, er, er, troubles

in an attempt that it might go away or I might not have to do anything about it?

(Interview 3: Senior clinician, Male).

Using personal emotional phrases in relation to the person assessed such as, “I fear”, may mean that the interviewee is demonstrating that he is noticing a feeling in himself. The continuation, “I fear that if, if I am, if I am oblivious to her cutting, she will cut deeper so that I am not blinded to it”, reveals a reflective relationship between the interviewee and the subject of the assessment (Chapter 1 and Figure 1, page 34). The potential for being able to receive a projection from the patient is there. The communication, the preliminary to containment described by Bion and Melanie Klein as projective identification, (see Chapter 1 and Figure 1, page 34) is possibly present in that a communication of feeling, “Fear”, has taken place.

Faced with dealing with death, this interviewee acknowledges how the impact of his response and wish to avoid thinking about death or suicide could be experienced by the patient as a rejection or cut which she could use to escalate her suicidal behavior. What is demonstrated here is thinking about the dynamic, the container and contained of psychoanalytic containment, and there is a questioning how this could be used to inform practice. If, “Oblivious to”, is seen as, “Could be experienced as if it’s done to me what’s done to her”, a rejection or hurt, this would mean attention and, in the instance of the expression of self-reflection in this interview, absorbing the horror in order to manage it. This however is not made explicit.

A different interviewee notes how difficult it is to absorb the feelings and allow a process of emotional containment. The interviewee uses the word contain directly:

I think that can be summarised by saying this felt like this was the truth of her, whereas the previous history felt like, 'Yes, this is kind of epi-phenomena. This is what is important'. I felt the anxiety of, 'How do we keep her alive when she cuts so deeply and stockpiles?' So I think what I've...what I've been talking about are the anxieties, the really...and the horrors that these patients have been experienced in provoking us and how difficult it is to contain that, and keep on trying to think about what's going on

(Interview 7: Clinician, Male).

The interviewee mentions anxiety and identifies, "Previous history", as an, "Epiphenomena", and the account of the assessment sessions as, "The truth of her." This is followed by, "I felt the anxiety of it". There are two stances, one of dealing with an epiphenomena and one of the truth, which provokes anxiety. The action of the speech in moving from something called history to something called truth may represent in this interviewee a distancing from and then coming to recognise feeling. There is no further development, at this point in the interview, beyond the recognition of a feeling but there is a direct reference to containment. The link between a reflecting 'I' and the idea of containment is made in terms of being about being able to, "Keep on trying to think", in the face of disturbance.

A position of a reflecting 'I' as being in immediate response to the feelings evoked by the patient was rare. From another interviewee there is another explanation for why there might be such a need to disown:

So I suppose if I'm completely honest, there...I think I was struck by feeling really sad...but also as a professional. It...it can feel, I think, quite intimidating to, erm, be presented with such a plethora of high risk complexities, and it's your job or you're part of a team whose job it is to try and, erm...try and work through them. And I think it can feel like a really tall order, and it can make you, I think, kind of think, 'Where do I start?' and, 'Can I do this?' Erm, I think those are the things...those are the things that were really in the forefront, erm

(Interview 14: Clinician, Female).

This interviewee does attribute feelings to themselves: "I think I was struck by feeling really sad", followed by, "But also as a professional. It can feel, I think, quite intimidating". The nature of the intimidation is not attributed directly to society or to the organisation as such but to a sense of feeling incompetent or possibly inferior: "It can make you, I think, kind of think, 'Where do I start?' and, 'Can I do this?' Erm I think those are the things". Others have power and knowledge. This interviewee is positioning themselves as a professional and a person without the sense of knowing that appears in some other interviews. The language itself is hesitant with, "Erm", included and a repetition of, "I think, kind of think". This interviewee is identifying herself as less knowledgeable and perhaps less powerful than others in the organisation. It may represent her place in the work hierarchy, which was less senior than some, and/or represent someone who feels less confident. It raises a question about how much the hierarchical structure of the organisation and the politics of gender influence the approach to containment and the processing of the ideas and feelings around suicide and death.

“Sad”, emerged as an identified feeling in some interviewees, as in two of the excerpts above, although the dominant feeling consistently identified in response to suicide risk was fear.

This feeling of fear was often projected into a position, which included the job, being a professional, being senior and a feeling that the institution itself was the location of the influence and responsibility. In the excerpt below the reason for attributing fear to fear of the power of the organisation or another position of seniority or superior knowledge was identified as: “It just becomes unbearable if they...you can’t go home at night knowing that person is in some kind of place where there are some people there, you know”. The move in the speech from, “If they”, to, “You”, shifts the identification from a distanced position to other staff to one of identification which includes a concept of a personal self, the interviewee, and me, the interviewer, as together. The phrase, “You know”, at the end of the excerpt reinforces this. “Unbearable”, is used as the reason for an idea of feelings that cannot be borne alone. This could be an acknowledgement that a psychoanalytic concept of needing two minds to process murderous feelings is relevant to thinking about how to respond to suicidality, or just to a theory that people who are suicidal should not be alone implying a physical presence is needed. With the idea of physical presence, no other emotional function is necessarily implied:

I mean clearly for some of our patients you need the physical containment. You know, some people are extremely close to destroying themselves. And I think also for staff as well. I think if you are working with very risky patients, actually, it just becomes unbearable if they...you can’t go home at night

knowing that person is in some kind of place where there are some people there, you know

(Interview 14: Clinician, Female).

The projection of fear of patient suicide became one of, “A harsh place”, with one interviewee:

You know, it's your role to provide that safe place, because, as a recovery coordinator, if it goes wrong, well, you are the one that ends up in a harsh place in the Coroner's Court (laughter) if you don't hold that and if you don't manage that

(Interview 19: Clinician, Female).

There is a statement of the position of the professional, “It's your role to provide a safe place”. The use of, “Your”, distancing the concept from a more personal, “Me”, or, “I”. The use of, “You”, seems to imply both all professionals and me, the interviewer. What happens to the professional is that they end up in the harsh place, “You are the one that ends up in a harsh place in the Coroner's Court”. The professional is placed in a paranoid position. In psychoanalytic terms this would be a paranoid schizoid position where a thinking process cannot happen.

In this section the use of the reflecting ‘I’ in relation to emotions and disturbance has been described. This use of reflection exemplifies part of the process of psychoanalytic containment (see Chapter 1). There has also been a description of

how people wish to avoid reflecting personally and are focused on other emotions: fear; sadness and powerlessness.

4.2.3 Internal conflict about suicide, self-harm and containment

This section identifies internal conflict in the interviewees, shown in the way they describe different positions within themselves. Sometimes this conflict appeared to result in anxiety and sometimes in an inability to think.

A kind of paralysis in fear was evident in one interview:

We don't have the training in CBT and DBT, so trying to...you just feel like you want to help the patient more, explore the...their feelings more, but you're not...you don't want to do it in the wrong way, because you don't know what you're...what to, erm, pick, or what to talk...you know, what to do with to help the patient in the long term. You're just trying to minimise that risk at that time

(Interview 20: Clinician, Female).

Here the paralysis seems to be in an impasse in a conflict between the personal and professional. The intertextuality evidenced in the references to other therapies by abbreviation (CBT, cognitive behavioural therapy and DBT, dialectical behavior therapy) is text from an unknown world of professionalisms. The impasse of not thinking is evident in the content and the form of the language. "You just feel like you want to help the person more". This seems to acknowledge the personal conflict and also a proposed identity with me and then this is followed by the hesitancy and the, "But you're not... you don't want to do it in the wrong way, because you don't know

what you're...what to, erm, pick up". The position seems to be of someone in conflict with their own feelings who doesn't know and can't think about or do anything other than, "Minimise that risk". "Minimise", I understood here as being about physical control or reassurance rather than any recognition and any form of emotional processing of feelings by the staff member. Also implied in, "We don't have the training", is the idea that there is a different approach possible but that the knowledge of this rests elsewhere. The projection is into specialists and specialist training and by further implication staff at a distance higher up in the organisation. The position of paralysis is a somewhat helpless state, of someone without knowledge and power and in an internal conflict between their emotional and professional selves.

In contrast to those who projected responsibility and management into the institution, professionalism, training or others there was one interviewee who acknowledged that a, "Belief", was significant in allowing them to offer something that they defined as containment.

If we can't talk about those issues, then it's difficult to support somebody with those issues. So, you know, if you feel, or if one feels uncomfortable talking about weight, say, or cutting, or sexual abuse, or whatever it is, then you're going to be silencing somebody, because you're not comfortable enough to kind of...it's back to that containment again, isn't it, and making somebody feel safe and it's okay to talk? With a view, a belief, that that is going to be helpful and not kind of...erm, re-traumatising for them

(Interview 5: Clinician, Female).

The position is of identification with me, the interviewer: “So, you know, if you feel, or if one feels uncomfortable”, and perhaps with an idea of staff that is more general. The concept of containment is more complex than just the physical, “It’s back to that containment again, isn’t it, and making somebody feel safe and it’s okay to talk? With a view, a belief, that that is going to be helpful and not kind of...erm, re-traumatising for them”. The intertextuality of, “Back to that containment again, isn’t it”, refers to containment as a concept that is assumed to be shared between myself as the interviewer and the interviewee. It is assumed to be greater than physical containment or feeling safe and to include talking. The concept of containment is presented as one that, if it includes more than physical holding and presence, is a, “Belief”.

In this section internal conflicts between the personal and the professional have been identified together with the resulting anxieties and inhibitions to thinking or processing emotions. Belief is presented as a way of avoiding anxieties or paralysis.

4.2.4 Summary: How do staff talk about suicide, self-harm and containment?

The question at the start of this section was concerned with suicide and death and asked how people talked about this. People took up stances as professionals or staff; sometimes in the widest sense of staff belonging to a health profession, and sometimes in a narrower way as a particular group of professionals or staff. Some people took a stance of being the one or ones who knew or understood as theoreticians or professionals, remaining at a distance by using the concept of the

patient as general and other. When there was a self-identification with feelings in a personal sense this was frequently in conflict with the perceived professional or institutional role. It is likely that this conflict is a source of anxiety, as was expressed by several interviewees. The description of conflict entailed the use of two different texts concerning identity; one related to the first person and one related to a second or third person. It is also the case that this anxiety about a personal state of conflict and the fear of being outcast as a professional by the wider institution may contribute to a climate of fear and a regression to a paranoid schizoid place, where thinking and reflecting become hard or impossible to do. In this climate curiosity and thinking can be abandoned and action takes over. This often takes the form of physical containment or action. The text of the professional is common and probably was used extensively in response to my also being a professional. This professional intertextuality seemed to be related to theories, which could be psychoanalytic, about talking and processing feelings and needing two minds rather than one to engage with particularly difficult feelings.

People adopted a stance of themselves as powerful in some instances and powerless in others. There were also several comments about gender perhaps underlining the significance a male dynamic, which could be identified with power. The instances of a stance of power and control seemed more common in relation to hierarchical position than gender but this was not true in all cases.

4.3 How do staff talk about themselves in relation to the assessment?

This section of the analysis focuses on the entirety of the interviews and investigates how people position themselves in relation to the patient in the assessment; whether they demonstrate any thinking or self-reflection and whether they can develop this thinking into something that could be an emergence of the symbolic or representational. Inevitably the context, the relationship with me as interviewer, forms part of this analysis. Positioning, stance taking and intertextuality are used in the analysis in this section. There is also comment on the use of the discourse marker, "You know". The discourse analysis, as described in Sections 3.7.4 and 4.1.1, 4.1.2 and 4.1.3, uses these approaches as a way of investigating the avoidance of containment as well as a way of identifying a self-reflectivity that may indicate psychoanalytic containment.

The analysis is divided into sections: curiosity; the institution and professionalism as avoidance of containment; the internal conflict between selves and staff as container. The previous section identified stances of power and powerlessness, conflict between personal and professional selves and ways of using theories to deal with disturbance. These are further explored in this section together with a section identifying where staff might be close to replicating the psychoanalytic idea of containment.

4.3.1 Curiosity

One interviewee implied that they were interested in the patient but in the context of being unsure about how to position themselves:

I mean, the older you are, you look back, and people didn't do touchy-feely then. You kept your stiff upper lip, and, 'I don't want to talk about it', and it was all about brushing it under the carpet. And if we don't talk about it, it doesn't exist. Er, now, of course, we've gone to the other extreme. (Coughs) Everybody wants to tell everybody about the most intimate things. But she...it's, it's interesting, because I really would like to know what, sort of, age/era she's in, you know

(Interview 1: Administrative/Clerical).

The interviewee seems to consider how to position herself: as the same age and therefore in that way to identify with the patient or as part of the newer generation that talks. She seems to be uncertain where to position herself when she says, "Er, now, of course, we've gone to the other extreme". The statement, "And if we don't talk about it, it doesn't exist", seems to be both an acknowledgement of a past position and a provocative statement to the interviewee themselves and to me. Within the position there is a question and curiosity, "It's interesting". Yet there is hesitancy, perhaps in relation to approval seeking from me, as senior to her.

In the final sentence, "But she...it's interesting, because I really would like to know what, sort of, age/era she's in, you know", there is curiosity and also an identification with me in the, "You know". This marker seems to communicate a meaning that ensures that the interviewee is not alone. It is implied that curiosity is also needing another mind.

From the, “You know”, phrase search using NVivo this was the most commonly used phrase in all the interviews. In contrast the phrase was not used at all in either the assessment text or the written memos of reflection written after the interviews. This discourse marker is well known (Swan, 2005) and has also been the subject of research linking the use of the marker to a function of personality (Laserna, Seih and Pennebaker, 2014). In their paper they suggest that rather than being an expression of anxiety a marker may be linked to a conscientious personality. This suggestion is at variance with the suggestion made in this analysis, the suggestion that the marker, ‘you know’, is a reference to the dialogic nature of the interview and to the idea that two minds are part of a way of thinking about the material of the assessment.

The idea of interest surfaces in another interview but this time in a more generalised sense with an implication that the interviewee is positioning themselves, partly as themselves and partly, or mainly, as a professional:

So it's clear that undertaking therapeutic work with people with this level of difficulty is both very disturbing for the people working with it and very disturbing for her, and isn't an undertaking to be, er...isn't to be undertaken lightly, um, or without very careful thought. However, it seems to me that the alternative of, um, er, treatment...of, of not addressing the emotional difficulty and, um, er, and, and simply failing to recognize the problem, and, er, treating it almost the same way as though it were a psychotic disorder with medication and admission, doesn't seem to me to be a reasonable solution for a group of patients who are so troubled, and, er, where really the possibility of

therapeutic work under the right circumstances hasn't, hasn't even been tried. And if one considers that about a third of the patients presenting to the mental health service fall into this group, this seems to me to be an enormous unresolved and under-researched problem in mental health services. And, er, so I'm both very interested in it and very keen that we should do our best to try and do something about it, at least to find the limitations of what can be done or, where it's clear that somebody is beyond the point at which they can use therapeutic work, what can be done to support them to have the best quality of life they can manage. Um, or at least that the people who are working with them should have reasonable understanding of what the problem is and so be able to talk to them in a way that demonstrates some understanding of what the problem is and so be able to talk to them in a way that demonstrates some understanding of the difficulty to the patient. Because it seems that without, to me, that without that, these states of mind are, kind of, unendurable really. So, um, er...So that, that's the reason for my being interested in it

(Interview 10: Senior clinician, Female).

Here interest and curiosity seem to be mainly from the position of a mental health professional within a wider institution of staff, although there is the statement about the states of mind of this group of patients being unendurable which includes self-reference, "To me". This raises a question about how much of the sense of agency, orientation to the patient and representation is being projected into the idea of self as a professional and careerist within the mental health field. The intertextuality is one of a mental health professional, which is at one point used as a stance marker in

identification with me as interviewer as, “We”. I was, in this case, a member of staff in the same unit as the interviewee.

In this interview there is a statement that the idea of containing the emotions of this patient group is not possible for one individual as they need the same process to be available to them. This is restricted and distanced in a statement about staff rather than being a reflection about the interviewee themselves and so, although this could be implied, it is not openly acknowledged here:

And support, because actually starting to think of it as an emotional issue means that you have to engage with it emotionally. And that’s very difficult. It can’t happen without a proper container for the staff, proper support and supervision and thinking for the staff

(Interview 10: Senior clinician, Female).

4.3.2 The institution and professionalism as avoidance of containment

Another interviewee was almost entirely positioning himself at a distance, perhaps as a corporate idea of himself together with me, as the institution. The description included many references to, “You”, and, “You know”:

One of her experiences with that engagement was going back to sleep, and, erm, whether, you know...it’s difficult to comment on each situation, but what you’d...what I’d want to see, if I was working on a ward, or a manager of a ward, is that when people express, you know...they wake up quite distressed, erm, you know, my experience was, when I worked on an older person’s

ward, we wouldn't tell someone to go back to sleep. Actually if they got up in the night, you know, we would say, 'Look, do you want to come out and chat to us if you can't get back to sleep? You know, 'Let's make you a cuppa'. Erm, 'Tell me a bit about how...because, you know, that was a dementia ward. And, erm...but even on any ward you would want the staff to appear to be more sympathetic, but want to find out about really what was going on for her and what these dreams were about

(Interview 11: Clinician, Male).

Here an idea of self as a personal container of feelings is suggested with the use of, "I", but this is presented sometimes as "I" the organisation as in, "But what you'd...what I'd want to see".

In this interview there is also a reference to literature about co-production as if another discourse is looked for as a corporate response:

But you want the people in hospital to be sympathetic towards you, erm, and the other thought about that, which was going through my head, was, erm, some of Julie Repper's work that she is doing on co-production. And I'm not saying this from a, sort of...having peer support workers, erm, and I'm not sure if it's either been explored, peer support workers, for people with BPD, erm, but is there something that we could be doing there?

(Interview 11: Clinician, Male).

This was a reference to a concept and lead figure in the recovery initiative and a different discourse concerning mental health services. The word co-production was

an unfamiliar one to me but was taken from the discourse of the recovery movement. It was an example of intertextuality. I had to investigate the meaning after the interview. The meaning seemed to be co-production of care between service user and staff. Someone, Julie Repper, was named as an expert. This was presented as being different to the position of us as the interview pair in the present. "Is there something that we could be doing here?" I am invited to participate in something different that involves a co-production dynamic, which is not explained in the interview. It is presented as if I have to join a different organisation. Possibly there was a sense that I was from a past, old school and the interviewee was from a new, young school of thinking. In fact, I think there was little age difference between us. This interviewee seemed to identify himself primarily as a change agent in the organisation. This related to his job role.

There were further statements in the interview such as, "What systems can we put in place?" Then, "I don't think there's enough expertise in the organisation". It seemed that it was a transformed organisation in the future, which would be able to do the containing and treatment of this patient group. This was distanced from me and the interviewee, a future only. In the field note I wrote how I felt invited to join a futuristic more ideal organisation as if I was part of a poorer current world.

Compassion was a word that arose in this interview: "As a nurse it shocks me to think that we have to teach people to be compassionate, you know, in this role", (Interview 11: Clinician, Male). Although a dictionary definition of compassion is, "To suffer with" (Shorter Oxford Dictionary, 1983), the use of the word "shocks" and the tone of the comment in the audio material are mildly angry implying that the kind of

identification called compassion is not common. It also is linked to a nurse role. He continues to say that to enable this compassion to be sustained: “The key for me is about leadership and training”, (Interview11: Clinician, Male). Again another mind is seen as necessary.

In an interview with someone from the category of Board Member, the position seemed to be one of a self merged with the institution or even society as a whole or at least with other senior professionals. “I mean, we’ve always admitted people with these kind of, difficulties to wards, because we can’t help ourselves, and society requires that we do it” (Interview 13: Board member, Male).

The position is often of a superior, “We”:

We can now use some understanding of queuing theory, psychological queuing theory as to why the little thing escalates to the bigger thing, to the massive thing, to the cut or to the trauma. And if we were to break the person’s risks down and understand them as the journey to the self harm moment, and where the self harm moment might lead to the suicidal moment in terms of being really clear about the difference between the suicidal intent and why people shift, because we know these things

(Interview 13: Board member, Male).

The intertextuality here refers to an intellectual theory, psychological queuing theory. A further intertextual reference is made to Maslow’s hierarchy of needs theory: “I’m thinking. Well, in terms of Maslowian needs, job, food and

shelter, and a relationship that matters to her, that's too much to give up to do the hard work now at 23 or 24" (Interview 13: Board member, Male).

These three interviews (10,11 and 13), two from senior clinicians and one from a board member, are using different discourses overtly or implicitly borrowed from theoretical positions. Intertextualities are explicit in the interviews and distanced the interviewees from the case in the assessment and, in some parts of the interviews, from me as the interviewer. The countertransference from these interviews as recorded in the memos, was of people who elicited a feeling of inferiority and/or ignorance and could therefore be described as coming from a stance of power and control. This may reflect the uncertainty of these people in terms of dealing with the case and the patient group as well as anxieties about being the subject of research.

4.3.3 Internal conflicts

The difficulty of having several positions, 'I' as a feeling person and an institutional 'I' is acknowledged in:

And, and it is so difficult to separate, er, the concern...the, the, the concern from her, and I wonder if this is what blinds me sometimes, from an institutional...I'm not sure if it's a concern for the institution or...that was, that's supposed to treat her, or a concern about the, the, the commitment or resources or capacity of the institution to, to treat her

(Interview 3: Senior clinician, Male).

A problem is identified as an internal conflict between different selves, in this case the institutional self and the personal concerned self. This conflict was noted by another interviewee, who referred to a period when they were off sick:

I mean, the structures that we have got sometimes aren't adequate enough because the work can, erm, really impact on you personally, erm, and, you know, from my own personal stance, I was off sick because of...I felt uncontained in my work here. Erm, so there's a kind of transference from the patient and at the time lack of, I felt lack of support and supervision and understaffing. That, erm, had a definite impact on my health. So, you know, and it get...the work can upset you on...I find, on many different levels

(Interview 5: Clinician, Female).

Noticeable is the interviewee's use of feeling, "Uncontained", which is linked to, "Transference", from the patient and to a lack of support. The implication is that something called containment would be beneficial.

In Interview 7, which was with a clinician who, soon after the interview, went on long-term sick leave there is a further statement about a need for containment:

It's such a huge thing to take on when you have 16 people in a ward with that level of horror, and you might be dealing with your unprocessed difficulties as well. I think, erm, you don't set up the conditions for that more mutative, flexible containment which allows the full narrative to be told and the

possibility of change in that narrative as well

(Interview 7: Clinician, Male).

A question is raised from these acknowledgments of conflict and stress between the personal 'I' and the institutional 'I' or 'We' about how this can become something bearable rather than unbearable, as the unbearableness can result in sickness and withdrawal from engagement with the case in the assessment or others in the diagnostic group. From the earlier analysis of Interview 10 there is the acknowledgement about the need for another mind, which is summarised by one interviewee's response to the assessment: "I found that I was glad I was in the presence of another mind that was trying to think her way through things" (Interview 7: Clinician, Male).

One interviewee, a clinician who was about to retire and may therefore have been able to be less constrained, touched on an extreme and harsh view of the institutional "We" or in this case a more distanced "court":

I think it is a...for a recovery coordinator, and there would always be that hope to, to...not just a hope, there's also that sense that, you know, that's your role to provide a safe place, because, as a recovery coordinator, if it goes wrong, well, you are the one that ends up in a harsh place in the Coroner's court (laughter) if you don't hold that and if you don't manage that

(Interview 19: Clinician, Female).

The institution, or court in this instance, has become identified as a persecutor. The conflict between the person, “I”, who wants to get it right is strongly in contrast to the court where that, “I”, can be wrong and punished for that. This difference is between an, “I”, which is identified as a role, “Recovery coordinator”, whereas the conflict was differently expressed in other interviews (17, 3, 14 and 15) as a positioning of ‘I’ personal and ‘I’ professional/institutional. In all cases the difference is made explicit in the text. The conflict is presented as an anxiety or stress.

A further question arose from the analysis which concerned how people talked about the way of dealing with their internal (number of selves and different positions) differences and conflicts.

“It does feel a bit like trying to weave a, a safe web” (Interview 19: Clinician, Female), was one perspective. “People who are working with them should have a reasonable understanding of what the problem is” (Interview 10: Senior clinician, Female), was another. Neither of these were linked to a reflecting self or ‘I’. There was, in Interview 10 though, a description again of the difficulty, “Actually starting to think about it as an emotional issue means that you have to engage emotionally. And that’s very difficult.” Emotion here is a word used in connection with the personal reflecting self or ‘I’.

Interview 2 (Middle management, Male) includes a reference to me as interviewer by, “Isn’t it?”, for a position that is closer to a personal reflecting self:

I mean, it’s really important to face that, isn’t it? This is the nature of the work, isn’t it? This is, er, this is what we do, um, and I, I suppose it’s the purpose of

what we do, er, that I think keeps people going, um, and not having to shut down, er, emotionally and psychologically to, er, to bear witness to, um, kind of representations of these horrible things that have happened, um, I, I think

(Interview 2: Middle management, Male).

Emotions or feelings were identified as a problem in (Interview 11: Clinician, Male): “And to this day I feel guilty that I never engaged with that particular person”. Interview 13 (Board member, Male) included the statement: “So I am mindful about...and increasingly so with my career stage, of which bits I can afford to address?”

Interest is identified by one interviewee as being a necessary part of being able to bear disturbance. This is expressed as about others, (Interview 17: Clinician, Female): “To me, it makes sense to have some sort of separate provision and to have people who are interested, who want to explore this”. Whereas a different and more distanced approach is identified in Interview 18 (Senior clinician, Female): “Because containment feels like it’s something that we are doing something around a person, to a person, and I come from a different perspective where I feel it’s a person learning to manage themselves.” This reference to the emphasis being on the other as in the patient, not the ‘I’ or the ‘We’, was evident in another interview:

I was, um, out in Holland, and very struck by the difference. They, um, offered patients, um, choices, and the choices were, um, to be safe, er, for yourself or safe with others. Er, you could choose, in their words, um, chemical restraint, which was taking drugs, you could choose, er, seclusion, um, and that was a

way of you being separated, er, or you could choose physical restraint. And this is ten years ago. And people were walking round in straightjackets, which I found very disturbing, but actually...they'd chosen it. And what they said and were able to articulate, 'If we use chemical restraint, it does our head in, we can't think normally. Um, this enables us to be in the community, we know we are not going to harm ourselves or hurt anyone else, and it enables us to think.' It was very interesting

(Interview 9: Board member, Female).

Here interest defines an interest in containment although the way of relating to disturbance is from an observational distance. The sense of conflict between selves is less evident than in the other interviews in this section. The interviewee is a Board Member and more distant from clinical practice.

4.3.4 Staff as container

There were people who used the concept of 'I' to reflect on a personal position with the type of case, although in the instance below this was about a reaction to a type of case, rather than the personal of the particular case in the assessment. In Interview 12 (Senior clinician, Female): "I, kind of talk about, I, kind of, feel like I'm a big sister, I'm having to help them grow up". The, "I", here is referred to with reference to another internal mind; a concept of a big sister. This interviewee makes a suggestion about what may be missing for the person who is the subject of the assessment:

I just can't help wondering, you know, has she ever had a parent for example, that says, 'You look sad,' or that, that way of, of helping to kind of make of being noticed, of being, of being seen?

(Interview 12: Senior clinician, Female).

This openly acknowledges the need for another mind, a parent in this case, who could do a process of seeing and being noticed. Implied in the, "I...feel like a big sister", though is an assertion that the interviewee takes a stance which is one of being different and superior to the service user and as being one who could enable the person to develop a changed perspective on what goes on in their mind. A question is raised here about whether the idea of containment in the psychoanalytic sense, implied in the process of being a big sister, is parental and or/superior. This will be returned to in the discussion. This interview was with someone from the category of senior clinician.

In another interview the concept of 'I' was expanded and positioned in a different way. Here there is more reflection on the interviewee's sense of 'I':

I was wondering if she perhaps felt as though she had no skin. No...no armour, erm, no container around her. Erm, or perhaps had been lacking the protection that she needed when she needed it and when she was growing up. And, erm, it...it brought into my mind an image of if you have no skin, how...how many things would be so painful. Erm, I was thinking of the saying 'rubbing salt in the wounds'

(Interview 14: Clinician, Female).

And later (Interview 14): “I didn’t get the feeling that I would find her too much to bear. I didn’t get the feeling that she...that I would be afraid to work with her for what it may trigger in me’. However, the interviewee continues to say:

It would be...it would be very difficult for any one person to be trying to, erm, work through these difficulties with her. Erm, and...and I...my suspicion would be that she perhaps wouldn’t, erm...that she would receive a better service if there...if there were...If there were more people involved, there were more...there were more minds. There was...there was more containment, erm, and...and the container was more robust

(Interview 14: Clinician, Female).

There seems in the progress of this interview to have been a development in the sense of a representation and symbolisation of the person’s pain, as understood from the assessment, into a comment about containment. There is curiosity about what the experience of the person is and how this can be used. Near the end of this interview something seems to be given as an example of how, for this interviewee, such containment might work:

...the dead birds all over the floor. ‘What...what does that mean? What does that...? Where does that come from? How does that make you feel? What...what do those feelings feel like? Erm, and I...I think we would be using that, erm, as a way to generate more discussion and more reflection and more exploration of...of what this is

(Interview 14: Clinician, Female).

Another interviewee developed this concept of containment in a different way although acknowledging again the difficulty of bearing the distress alone:

You know, it makes me want to weep and, you know. I'm in therapy three times a week. I've got fairly robust structure that I can bear to be in touch with this and be held and contained myself. And most people haven't got that. And it...(sighs) so I think it's a huge ask... So it's kind of...It's being sufficiently in touch with it, but that also you are still able to function within that as well in a way that's hopefully useful for the patient

(Interview 17: Clinician).

The relationship between the "I" that wants to weep and the "I" that can work with the person presented in the assessment is dependent on the relationship of the "I" to another, in this case a psychotherapist.

These interviews (Interviews 17 and 14) were with people who worked within the personality disorder service and they were both clinicians. In interviews where the interviewees were from management or board level or, in some cases, senior clinicians the distinction between the 'I' sense of self and other selves, for instance work selves, were more clearly identified as different positions. These people distinguished in their language differences between their different selves. One person stated:

I guess, fundamentally, as a woman, um, and a wife, and you just really want her to be safe and well and supported. Um, and, um, and so that is my first

feeling, if I'm honest with you, um, and that's the, then...You know, if I put that into my work context, then I think about, well, how are we best placed? Are we the best people to treat her?

(Interview 15: Board member, Female).

However, in one interview (Interview 4: Clinician, Male) personal emotional disturbance as 'I' was talked about in the context of the immediacy of the relationship with me as interviewer. These excerpts from that interview may demonstrate a two-person process of being disturbed and being able to represent and find a sense of relief:

It's the detail that kind of makes the stuff, you know, really emotionally powerful. And there was something about, you know, the brambles and the blood and being raped from behind, all that, which was, erm – part of the deal, which was pretty terrible, I think. It reminds me of, erm, listening to someone who was, err, put into foster care and then raped by her foster father tied to a bed and left on the bed and raped repeatedly by him. And you know you can hear this sort of stuff.

I suppose I do feel a bit more hopeful as I've talked about her, umm, and there has been a-I was talking about- thinking about her voice rising to a crescendo, that, umm, you know, where I started was in quite a dark place about her, rather feeling myself to be overwhelmed and unable for it- and I feel less like that now, having talked about it and got inside the material a bit more. It's hard work with her.

In terms of a, kind of, parallel process...but through the process of reading, thinking, talking to you, maybe even my voice has changed, you see, err, which might be on the tape, you know, as her voice changed in the session, you know, I certainly feel less tired now. I feel more lively

(Interview 4: Clinician, Male).

The interviewee seems to come closest to the psychoanalytic definition of containment within the process of the interview itself. However, this was rare and only two interviews (Interview 4 above and Interview 3, see section 4.2.2) seemed to consistently demonstrate this level of a reflective self.

4.3.5 Summary: How do people talk about themselves in relation to the assessment?

The analysis shows that people sometimes approach the person in the assessment with a level of curiosity. The curiosity can be positioned as something personal or something professional and is always within the context of the relationship with me as interviewer. The use of a professional identity as a subject position is sometimes used to avoid any reflection on personal emotions in the interviewee. People used a variety of other texts to give a sense of professionalism or distance. When they did articulate feelings people identified the conflict between these feelings and those of the institution or profession as stressful and 'uncontained'. Only rarely was containment of personal feelings noted as possible.

In the definition of containment given at the beginning of this thesis (Figure 1) some disturbance in the second person or within a reflecting self is essential to the process. Emotions need to be acknowledged in order for symbolisation and representation to take place and for the emotions to become bearable. The difficulty appears to be, from this analysis, that many people lack a way of processing the disturbance and conflict expressed by different selves leaving them either distanced or susceptible to their own anxieties.

5

Analysis: Psychoanalytic Defences in the Interviews

This section, as described in Chapter 3 (Methodology, page 74), takes as a basis Billig's (2006) idea of a psychoanalytic discursive psychology. Billig (2006, p.21) refers to the key to this kind of analysis being about emphasising the significance of repression in the construction of discourse, rather than searching for the unconscious, which he says has led to vague analysis. The focus of the exploration in this analysis is on defence mechanisms in line with Billig. However recent writing on defences, and in the writings of many psychoanalysts including the later Freud (1927), Klein (1946) and Britton (2003) present a more complex view of defence mechanisms than the original single idea of repression.

The definition of defences used for this analysis is taken from the New Dictionary of Kleinian Thought (Eds. Spillius, Milton, Garvey, Couve, and Steiner, 2011). Here (Spillius et al., p.305) it is stressed that defences are seen as part of ordinary human psychological activity. It is only if they become rigid or extreme that they are pathological. For Klein defences were divided into two: defences of the paranoid schizoid position, seen as defences against the death instinct and annihilation, and defences of the depressive position, seen as defences against feelings of loss of and guilt about damage to the 'whole object'. The focus, for the purposes of this analysis, will be on the defences of the paranoid schizoid position. In the dictionary (Spillius et al., p. 307) these defences are named to include: splitting, denial, idealisation, projective identification and introjection. It will therefore be an analysis that is limited

in scope and will not attempt to relate all psychoanalytically defined defence mechanisms to the interviews. The choice is made in order to explore the primitive defences that may avoid the process defined psychoanalytically as containment taking place.

This analysis identifies ways in which subject positioning and intertextuality reflect the psychoanalytic defences identified above. In the process of this analysis I made use of matrix, linked coding reports such as the example given in Appendix Q.

5.1 Splitting

This defence, in Kleinian terms, is a binary split between good and bad aspects of the self (Spillius et al., 2011, p.491) and is active from the beginning of life. It is the paranoid schizoid view of the object and a necessary developmental and continuing process. It is a protective defence, which enables the mother or object to be preserved as a good object. As her work developed, Klein (1946) linked splitting to the fate of the split off parts of the ego with projection and projective identification. Later the term was used by Bion (1957) with reference to an internal split between psychotic and non-psychotic parts of the self.

Finding instances of recognition of splitting and some resolution of a split was unusual. Containment, which would imply this kind of settling, was talked about as a concept (see Section 4.3.3) but rarely closely linked to a process evident in the discourse of 'I' as the reflecting emotional self or to the lively sense of the interview as part of that process. Only Interview 4 seemed to express both a concept of 'I' as a

reflecting self and as a response to the live process of the interview itself. In seven of the post interview memos though there were references to people saying, after the recorder was switched off, how they had enjoyed the process of the interview. This could be expressing some appreciation of having time to talk about disturbing cases and a reflection on some sense of settling disturbance.

One memo included the note that the person had said that doing the interview had been interesting and: "A real rest from my normal job", and another memo recorded that the person had said that they: "Had enjoyed the process". One note made after an interview with an administrator said that the person thought she was underused and that she had found the interview really interesting. These comments made after the tape was switched off could be identified as a position of a reflecting self and may say something about the containing process of the interview itself. It is also possible that, after the recorder was switched off, the interviewee was able to feel less different from the researcher. The position became less hierarchical and any split that was occurring along the lines of power and the less powerful diminished: the defences enlisted in the formal context therefore also diminished.

What emerged from the analysis of the numbers of selves and positions in the transcriptions was an awareness of a conflict in terms of the difficulty of being able to reconcile two or more selves. This was evident in Interviews 17,14, 19, 7 and 3 as described in the previous section. In these interviews there is an articulated awareness, which could be described as an awareness of internal splitting, in that the interviewees are able to position themselves as a thinking third. An example is (Interview 3: Senior clinician, Male) as previously quoted:

It is so difficult to separate, er, the concern...the, the, the concern from her, and I wonder if this is what blinds me sometimes, from an institutional...I'm not sure if it's a concern for the institution or...that was, that's supposed to treat her, or a concern about the, the, the commitment or resources or capacity of the institution to, to treat her.

There is in this quote the position of the "I" who has difficulties: "It's so difficult", and is concerned and the sense of "I" an agency that is able to reflect on the position: "I wonder if this blinds me sometimes". The different concern of "I" is for, "The institution", with its commitment and capacity issues. This could be identified as a preliminary sense of agency or observational thinking third which would be a basis for a process of containment (see Figure 1).

The split, in other interviews, is articulated in terms of others. Interview 10: "So it's clear that undertaking therapeutic work with people with this level of difficulty is both very disturbing for the people working with it and very disturbing for her". This particular interviewee does not use a position of a reflecting self with regard to disturbance. It is, "People working with", who are being disturbed. A similar position is within the quote from Interview 11 (Clinician, Male): "A senior professional person sat there and went, 'Oh, borderline personality disorder'". Referring to the audiotape for this quote the professional's tone is of disdain. These positions could represent splitting in the sense that the unbearable or negative feelings are located elsewhere. They could also be named as projections in the sense that the feelings are located in other people.

A split was articulated in some interviews between the researcher (known to most interviewees as a psychotherapist) in the way that the researcher as a psychotherapist became responsible for the disturbance. In Interview 18:

And they would spend the last six months working towards the end of the therapy, and her therapy came to an end. And she absolutely de-compensated and then she got admitted to a psychiatric ward, and she poured petrol over herself and set fire to herself on a hospital bed, which seemed ghastly, again. And it was explained to me, 'Oh, yes, coming to the end of therapy is very difficult and this isn't uncommon

(Interview 18: Senior clinician, Female).

The potential split in this quote is between myself and the interviewee and also between the position of the interviewee as a psychiatrist and the researcher as a psychotherapist. Again the tone of the audio recording is relevant.

This occupational positioning as a way of splitting was made more explicit in the same interview and extended to the idea of a split throughout the organisation:

There is in the Trust, a divide, I would say, myself. You know, I think that, erm...yeah, I think that there is a divide. I think there are some trusts that hold a very rigid and firm line about certainly inpatient psychiatric care for people with personality disorders. And, I mean, there is a dichotomy between the therapies...a psychological...can I say psychoanalytic? I'm not quite sure, but a psychological approach, and a ...kind of a psychiatric inpatient acute care

approach in order to keep people safe in this restrictive, dismissive, 'Pull yourself together', kind of way, and I...I personally don't feel that those are the right places for people with emotionally unstable personality disorders. I think, throughout my career, I've seen...I think that they do make people worse. They escalate self-harming behaviour, and I don't think they do allow an opportunity for introspection and examining thoughts and making links between thoughts and feelings, and I don't think they do

(Interview 18: Senior clinician, Female).

There was further splitting acknowledged between professional positions in this interview and two others. The split was identified as between psychotherapy and psychiatry and between psychology and psychotherapy. In Interview 18 the comment was: "Well, it feels quite hard because we never know what goes on in therapy. Closed envelopes". (Interview 18: Senior clinician, Female).

In Interview 13 (Board member, Male) there was a similar split identified:

Firstly, we don't often get to read psychotherapy assessments. There's a secrecy and a lack of connection between psychotherapy notes and the general psychiatry notes that's problematic and also the architecture of the language in the report makes a number of, err... err, confusions with my use of language.

This senior clinician also appeared to turn an attack onto himself and his profession in relation to this service user group:

So the whole ethos of my approach to treatment is how do I recover you to real life and real life relationships well away from high tech medicine. We really don't want psychiatry, because psychiatrists can't help themselves. They're going to fill you up with drugs

(Interview 13: Board member, Male).

In this instance it was as if the split was between the professional position and the personal opinion position.

There is, later in this interview, an acknowledgement of a split in society in general between knowledge and feelings, which could relate to the note in Interview 18 (Senior clinician, Female) about a split in the Trust. In relation to a quoted recognition that suicide rates were higher on locked wards than in general society, "There's a real dissonance between what's known and what's felt". This could imply that a split is maintained in professionals and defined as what is known in Trust policies as, "The Trust", to defend against feelings of loss and anger, which occur around suicides.

The impact of a split between the personal and the professional was not only seen in the discourse of senior clinicians. In an interview with a nurse clinician:

Because it's...it's quite hard to, when...when...well, the majority of the nurses on the ward aren't...they don't have CBT training, or DBT training. So trying to

help a patient with that experience is quite hard. I think what we're trying to do is minimize the risk, trying to keep them safe

(Interview 20: Clinician, Female).

In a senior manager's interview, the split is articulated as between the systems of the Trust and the personal: "The RIO stuff and the diagnosis, and you get into all this avoidant and all that kind...to me, they are just words and a label, you know, for people's pain and people's experience" (Interview 8: Senior manager, Male).

There were instances, some spoken of in the interviews, of a split that was uncontainable. The split was also possibly demonstrated by the number of interviewees who left their employment soon after the research interviews, either with absence through sickness or through leaving (five people in total). The suggestion, when this was spoken about in one interview, was that personal feelings had overwhelmed a particular member of staff and that this was to do with feeling isolated from other staff; the other minds needed to help contain feelings (see Figure 1). In this case the split was here of a personal self, divided from the institution.

Something triggered her, however you want to say it, but I think she was touched by somebody's situation, and that generated a level of upsetness in her that she...

I think she felt left...she was the only one who was working the hardest to get the thing for the patient. So obviously you're going to wear yourself out with that one

(Interview 5: Clinician, Female).

5.2 Projective Identification

Recently the term projective identification has not been clearly distinguished from the term projection (Spillius et al., 2011). Projection is defined as the general process of transferring unwanted feelings and thoughts from the self to another and projective identification, as involving a more detailed analysis of what is projected onto whom and the impact of the projection on the other. Projective identification, in this respect, is an intersubjective phenomenon (Jordan-Moore, 2012). Bion (1959) differentiated a pathological form of projective identification linked to omnipotence and violence and a more normal form without violence and with a maintained sense of separateness. In the pathological form there is confusion between the self and the object. This is not the same as empathy, where it is implied that the sense of separateness is maintained.

In one interview there is an acknowledgement of an impact of a someone with a diagnosis of personality disorder, not the assessment case, on the interviewee.

So I'm noticing...because my weight fluctuates quite a bit, and I know on the Y Unit at the eating disorders, the staff talk about their weight more, and they kind of discuss the impact of that, but I know when somebody's not eating I overeat here. I've worked here two years and I'm only just realising that that's my pattern. So, like, I've put on some weight over the past couple of months

(Interview 5: Clinician, Female).

This is a description of what is thought to be an intersubjective impact, and one that is unwanted and violent in the sense that the 'normal' sense of self is derailed, "I know when somebody's not eating I overeat here". The projection would be of the starving self of the service user identified in the member of staff, who feels and acts on the impact of this by eating. The sense of separateness has been lost in the face of a powerful projection.

In Interview 11(Clinician, Male) the frequent references to the negativity of others and the stance of complete sympathy presented by the 'self' of the interviewee presented both a split between good (the interviewee) and bad (the others) and a projection of all rejection, 'bad' attitudes elsewhere into senior people and the organisation:

Automatically people think 'problem', hearts sink.

A senior professional sat there and went, "Oh, borderline personality disorder".

I...didn't get very much support. In fact one of the DBT therapists said, "I suggest you place him in a home".

It's a bit like, "Oh, you know. Throw them in and lock away the key".

"Oh he's a waste of space". You know, "He's time wasting". "He's never going to do it", because this guy would regularly threaten to end his life.

Some person who said...I won't mention any... "Well, you know, I just wouldn't admit them to the ward and we'd have to take the risk and if they kill themselves they kill themselves". And that was from a very senior person, you know, erm, and I think that's really sad, you know?

(Interview 11, Clinician, Male)

The cumulative effect of such comments and the stance of the interviewee, as allied to a 'good' researcher/psychotherapist, is reinforced by the frequent marker, 'you know', and gives this interview a sense of fixed positions of good and bad: myself as interviewer, the interviewee and 'others'. The fixed quality is known as a characteristic of projective identification and a psychotic aspect of the personality (Bion, 1959). The position of the interviewee and the other does not shift.

In several interviews projections onto me were clear. These were sometimes projections which implied that I was the one who knows, who was more powerful and sometimes the reverse with me being treated as inferior or ignorant. These projections, unsurprisingly, followed the hierarchical positioning of the interviewee: people senior to me sometimes projected ignorance into me; people junior sometimes projected knowledge and power into me. Analysing the interviews, where this kind of projective process was evident, it was more present in interviews where I was unknown or relatively unknown to the interviewee. There was therefore more scope for a projective process to come to the fore in that there may have been heightened anxiety and a heightening of fantasy about me.

In one interview from a senior clinician, senior to me in the hierarchy, several comments provoked my feelings of dismissal and inferiority. I wrote in about these in the memo written after immediately after the interview. In terms of my own responsibility for these feelings I thought that they were heightened by my arriving after the interviewee with him stating that he had arrived fifteen minutes beforehand. In the memo I noted that, after the recorder was switched off, the interviewee said that he had enjoyed the assessment and thought the assessment was good but had treated it as he would treat one written by a junior doctor. There were also comments in the interview about, "Me choosing to do a PhD which I might pay for myself", "being a breathing space"... "without doing any more work", which seemed to be comments directed towards me (Interview 13: Senior clinician, Male).

These comments meant that any sense of inferiority and insecurity on the part of the interviewee was projected into me as the interviewer. The impact was emotionally powerful and in the interview I made a personal disclosure about not always working for the NHS, thinking of a past and more senior job of my own. This was unnecessary and out of the normal range of my interventions. This was also an indicator of a projective process.

The reverse occurred in another interview, this time Interview 6 where the interviewee was an administrator: "As a psychotherapist, you know where you...you can help people to think as well" (Interview 6: Administrative/Clerical, Male). This time the knowledge and capacity is projected into me as a psychotherapist. A similar point was made in Interview 1, also with an administrator, who knew that my role was that of a psychotherapist: "Well, of course, I'm, I'm not a clinician. I think it needs

an awful lot of understanding and it, it needs some really deep therapy, doesn't it?"
(Interview 1: Administrative/Clerical, Female).

Projections were also made into the service user group as a group, as well as into staff and this occurred frequently. It seemed as if many interviewees, particularly those above administrator level, found it hard to stay with thinking and responding to the individual case in the assessment. One senior clinician in Interview 10 (Female) stated:

To grasp the complexities of this particular patient group requires a very sophisticated understanding of the problem and most people just aren't trained to even see it, to even recognise it. They are trained to work with particular clusters of symptoms and to do things that address those symptoms. And they...it, it just doesn't stand a single snowball's chance of getting to grips with this kind of, of level of problem

(Interview 10: Senior clinician, Female).

Here staff are described as mainly unskilled and the patient group as very complex. There is an elite group here who can understand, within which the interviewee positions herself. The invitation seemed open to me to join the group and, if not, to be unskilled. Ineptitude is projected into others.

In Interview 12 (Senior clinician, Female) there is reference to the case and others: "She does remind me of quite a few people who I work with with regard to eating disorders, who, in a sense, they don't have a vocabulary, an emotional vocabulary".

Here the 'other' is something more associative and less powerful and certain. This is an association and not a projection: "She reminds me". The interviewee is able to keep the individual case in mind and include others and the interviewee herself. There is more flexibility in this respect.

In Interview 17 (Clinician, Female), "So there's the constant pressure to discharge people (on the ward). So you don't want to open people up and make them more disturbed. You want to close them all down, give them some medication and get them out". Here the conflict is with a number of selves: the one who may want to talk and the one who wants to get rid of 'them' who is projected into the ward and the institution.

An acknowledgement of the stress and difficulty of dealing with split identities without resorting to projection is in Interview 7 (Clinician, Male): "It's such a huge thing to take on when you have 16 people in a ward with that level of horror, and you might be dealing with your unprocessed difficulties as well". The, "Huge thing," is the reflective processing necessary to contain the potential projection.

In Interview 13 (Board member, Male): "They've been entrapped by a malicious health fund social care system that has punished, imprisoned, and very often recapitulated the very abuse experience that we are seeking to treat". The pain is clearly projected into the institution/abuser.

5.3 Idealisation

Freud used this term in 1921 in respect of the act of love and in connection with the idea of narcissism and an ego ideal. Klein (1946) explained idealisation, as part of the defensive binary splitting of the paranoid schizoid position, when all the 'bad' aspects of the self are kept away and all the 'good' aspects are separated off. The fantasy 'good' object is perfect, a fantasy and omnipotent. The idealisation can be most active if the experience has been bad. It is a persecutory idea in itself, as the standards of the ideal can never be met (Spillius et al., 2011). The state of idealisation in this paranoid schizoid sense is understood to involve denial of other aspects of the self or world. If mitigated by a sense of complexity and imperfection the state becomes that of the depressive position. It then also loses its fixed quality.

The most prevalent idealisation in the interviews seemed to be around the idea of cure. The ideal is of a professional, and an institution in some instances, that has the ideal cure for something, which is, in this patient group, defined as a 'disorder'. Someone or something can provide the order and someone or something can keep the person alive.

The ideal of being able to keep people alive is manifest in the excerpt from Interview 19 (Clinician, Female): "That's your role to provide the safe place, because, as a recovery coordinator, if it goes wrong, well, you are the one that ends up in a harsh place in the coroner's court." The, "safe place", is the ideal position for this recovery coordinator and it has become persecutory.

In Interview 20, the clinician, in this case a ward nurse, said:

You don't know how to deal with it...They wouldn't know how to, err, react. It's about their anxiety to protect the patient and make them safe, but how do I feel...how do I make myself feel safe by trying to help them out? Does that make sense? It makes sense in my head

(Interview 20: Clinician, Female).

This was following a query about whether exploration of the patient's night vision could be undertaken by staff. Here the priority, the ideal, is, "Make them safe". The ideal of safety is also linked to the member of staff herself: "How do I make myself safe?" Risk, therefore, is to be avoided for anyone, service user or staff; the ideal is safety. This could be described, if a fixed position of the ideal is in place, as a denial of risk. This lodges all the concern for safety with the staff and institution thus removing the responsibility and difficulties of thinking and concern from the person diagnosed with personality disorder. This could escalate the projection, rather than containing it, splitting and fixing the position of disturbance or 'unsafeness' in the person with a diagnosis of personality disorder.

The concern about what the 'institution' can turn into in this respect was talked about in Interview 3 (Senior clinician, Male): "So, so it makes me wary as I think about that, as I could almost become complicit of the abuse with her and in the name of caring for her".

This raises questions about whether the institution can replicate the disorder of this service user group by enacting something physical and concrete, which repeats and reinforces the disturbance.

Several interviewees (Interview 1: Administrative/Clerical, Female, Interview: 7: Clinician, Male and Interview 6: Administrative/Clerical, Male) talked about psychotherapy as if it also could be an ideal: "I think she needs to talk. I really do think she needs to talk and talk and talk until she is talked out" (Interview 1). "I think there's an element of, erm, compassion, a kind of...an attentive, kindly, curious stance towards that and an attention to reach to that person without...without forcing a...forcing an easy solution to this" (Interview 7). "But then if you talk to someone who has, like, your skills and that, it helps you put a different perspective on I and then realise, you know, you are not living in the past anymore as well, that the past was before" (Interview 6). Others were potentially more denigrating:

I mean we are, as you say, in terms of subjective, you know, I know that if somebody is sharing stuff with me and the way they might be sharing it with me, I will be doing my own analysis of that, in terms of, sort of, thoughts about, well, maybe it's because of this, this or this or maybe it's because of that, that and that, yes? The reality though, sometimes is that I know I can be completely wrong

(Interview 8, Senior manager, Male).

In Interview 18 (Senior clinician, Female), "It does seem very mysterious they go off and have this therapy and for all we see is that actually...in the immediate term it

kind of makes people act out more. Not everybody, but we do see that it can be very disturbing and bring up lot of emotions for people". In this interview there is also reference to people, "Learning to manage themselves", with perhaps the implication that psychotherapy is unnecessary.

These approaches to the topic of psychotherapy are less rigid than the idealisation and denigration attached to the topics of safety and risk. The defences are less fixed and could be defined as more depressive than paranoid schizoid. There is a, "Not everybody", in the quote from Interview 18.

In terms of how psychoanalytic defences are employed in the interviews: there is evidence that the primitive defences of splitting, projection and projective identification and idealisation and denigration are all present. The question to be addressed in the discussion is how much these defences contribute to the lack of containment for the service user in the assessment report.

6

Reflexivity

6.1 Introduction

In this chapter I will describe reflexivity through my reflective log, field notes and supervisions. I will discuss the reflexivity involved in the single case assessment, in the interviews themselves and in the analysis. Reflexivity will contribute to the discussion chapter of this thesis.

The inclusion of material from my reflective log fits with how writing itself has been included in my definition of reflexivity in Section 3.1.6.

6.2 Reflective Log

From the beginning of the research project I kept a reflective log. This was written in the form of a journal, in which I captured my feelings and thoughts during the process of setting up and carrying out the fieldwork and the analysis. From this I am selecting points from the log that, on reflection, have influenced the trajectory of the research, the analysis and my own development.

Near the beginning of the research project I was part of an experiential group, made up of fellow professionals, thinking about how hard it is to locate, understand and bear disturbance and how the institution demands action rather than reflection. I

wonder how power corrupts, or not, containment and whether power and control are the concept of malignant containment, a mutually destructive container/contained relationship described by Britton (1992).

The group was the first in the series of groups, supervisions and consultations that happened throughout the research. They extended the reflexivity of the process. A quote from Bender, Hamilton and Tilley with Anderson, Harrison, Herring, Waller, Williams and Wilmore (2007) illustrates this: "It was like this, 'here are the results'. These completely fail to recognize (or don't wish to recognize) that archaeology is always an ongoing and very interpretive discourse in which there are always other possibilities, and multiple interpretations" (Bender et al. p.28).

I sense, attending the NHS Ethics committee for the research proposal, that some people on the panel react to the term personality disorder as something alarming and potentially untouchable. I realise that I am attempting to think and get others to think about some of the most problematic disturbance. I do some assessments: three assessments of the three referrals to the service in the one-month period allocated for this part of the research. I fail to get consent from the first person and persist with trying to get this via another member of staff. The reference to bondage, dominance and sadomasochism (BDSM as it was phrased in the first assessment) is echoed in some of my feelings. I am humiliated by the refusal and the person holds on to a powerfully direct statement: "I just want to kill myself". I can do nothing and the person refuses further engagement with the service. I have a strong sense of failure. I test out this assessment as suitable for the interviews with the learning set, perhaps with the intention of overcoming the feeling of failure. It is too long and

overruns the ten minutes within which people need to be able to read it. There is also a comment from the learning set that the assessment is written in reported speech, as if this is less valuable. Is it possible to get close to the experience of disturbance in the assessment/case study, will the endeavour of exploring containment fail?

Continuing with assessments I take them to a group of colleagues for consideration in an assessment workshop. Here it is the suitability of the assessed and the standard of the assessment that is thought about. The second assessment gets minimal time and is accepted and passed over. The others are endorsed. I think with a supervisor about my own countertransference responses that are written into the assessment and how I may keep these for after the interview based on the account of the session, so as not to colour the interviewees responses by direct acknowledgement of my own.

A few days later I have news of a completed suicide by the person who was the subject of the second assessment. This is immensely shocking and I have to question how much the assessment being part of a research project could have influenced this act. I feel a wave of guilt about my own optimism about assessing and treating patients and about my research. How ethical is it? Is disturbing people with assessments ethical? Is researching torment ethical? What does consent mean when someone has died? I have a dead end feeling. Is there such a thing as containment? Do I have any capacity for it? What seems to have been deadly to this person is the hope of containment and seeking a way out of torment. Months later the Root Cause Analysis Investigation Report on the case comes out. I feel it reinforces some sense of guilt and blame and that, in the original language which I

ask to be changed, there is a sense that I and other staff could have prevented the suicide. Brinkmann's comment is relevant (2012, p.12): "We have a situation that causes the researcher (in this case myself) to stop and wonder. Something seems strange, confusing and maybe even worrying."

I attend a training day and a description of the demands faced by staff working with people with personality disorder written by Rex Haigh is given as: "Bearing unbearable feelings, hate, murderousness and violence and sometimes deadliness in the countertransference" (Haigh, 1999). In order to move on with the research, I have to do this. I discuss with colleagues whether or not to use the assessment of a dead person and decide not to as it seems ethically wrong in that permission for use of the assessment after death has not been sought. I feel relieved but know that the experience is colouring the research and my own development. I decide to use the third assessment as a basis for the interviews and the subject of the assessment easily grants consent.

A preliminary meeting with a senior member of the Trust to discuss the research exposes that taking real service users to senior meetings has been tried and found to be "too much". The research is described by this person as "board to floor" and as something which was highlighted in the Mid Staffs report (Francis, 2013) as lacking. She says that this type of research has been missing from the Trust's approach and welcomes it. I felt the difficulty of bearing disturbance was understood and that the Institution would value the research.

I think, reflecting on the log and this first period of the research, that the selection of the method of psychoanalytically informed discourse analysis and of a focus in the analysis on how people positioned themselves in relation to suicide and death emerged from the impact of the suicide of the second person assessed. It was in part a question to myself about my own stance towards a suicidal service user and a reflection of the disturbance and sense of ethical crisis that I had felt. The process of engaging in the interviews and undertaking the analysis seems to have, “Reverberative qualities” (Taylor, p.14, 2012). Reverberation is for Taylor a description of what is passed backwards and forwards between analyst and analysand in terms of dream analysis and the process would conform to the idea of part of the process of containment, as described in Chapter 1, in terms of a dynamic iterative process which includes symbolisation.

I have, as I move into the practicalities of fixing and undertaking interviews, the sense that something about suicidality has become more bearable for me. Perhaps the research has something akin to the process of containment for me. Bronstein (2015) in a published paper that I first hear presented in 2014 talks about the recognition of form and symbolisation as being semiotic and links this to the ideas of Kristeva. “It seems to me that the emotional effect that can be experienced in the communication between patient and analyst depends in great measure on ‘semiotic’ aspects linked to primitive phantasies that are felt and lived out in embodied ways” (Bronstein, 2015, p. 926). This may also be what is happening in the research process.

In some ways similar to the process of analysis itself, as described by Taylor (2012), there is a backwards and forwards sense to the research. Resistances are part of the set up process. Initially the most senior person I approach is sceptical and the message is passed to me that researching containment has no purpose, as it is known already that the Trust is bad at it. Another resistance comes from cleaners that I approach. One initially agreed and then came to me saying that she did not possibly have time to do it. Another message came through that the cleaners' manager would not allow time for the research interviews. A second cleaner who was approached said that he did not have time to do the interview and a third that she did not like thinking about difficult things and would be upset and so did not want to participate in the research. In the conversations about the non-participation one cleaner said that anyway they were treated as, "Faceless people". From the top and bottom of the hierarchy of the Trust came initial refusals.

6.3 Field Notes from the Interviews

The question being asked in my research is not about what is a true or genuine attitude (Potter and Wetherell, 1987, p. 160). My methodological approach is a form of discourse analysis as described in Chapter 3: Methodology. Key to this method is a reflexive approach to the interviews. There were two parts to the recorded interviews: the first part where participants were asked to talk about whatever came into their mind in response to the assessment and the remainder of the interview time within which the interviewer participated in an unstructured way. The interviews were open interviews: they were free associative and, in the later part, discursive. Two other parts of the interviews were not recorded: the initial

period when I read the background history to the interviewee and the part of the interview after the recorder was switched off.

I wrote field notes immediately after the interviews. A key note in the field notes concerns the amount of time that people were able to free associate without interruption and how this varied from interview to interview. Also notable, because of variation, were the content of comments made after the recorder had been switched off. The field notes included how I felt after, and during, the particular interview.

The contribution of my own anxiety was significant in how long people free-associated to the material. I was aware that, unlike psychotherapy sessions, people had engaged in the research in response to request to be a participant in research. I felt invested in making this as anxiety free for them as possible. This was mainly evident in the interviews with people who were non-clinicians and were at a lower level in the hierarchical structure of the Trust. The impact of the power structure was significant. Staff at senior clinician or managerial level could speak for as long as fifteen minutes without interruption, which was approximately half the recorded speaking time. Staff, both clinical and non-clinical, who were lowest level in the hierarchy spoke sometimes for as little as two minutes before they paused, seemingly seeking reassurance. Consciously, I would then intervene, without addressing the anxiety but speaking to their response to the material, to alleviate their and my own anxiety. The type of interventions I made were agreements, "Yes", followed by a prompt question. One example of this was:

Interviewee: And also I'm struck by...I'm not sure what's real and what isn't, so I don't know whether she was raped or not, or whether it was a dream, or whether, um...

Interviewer: Yes. Is that because of the quality the dream do you think, that...?

Interviewee: Because she says she didn't know who he was, and she also says in the dream, but the dream...she doesn't know who the man is

(Interview 9: Board member: Female).

This intervention was early in the interview and in this example I noted in the field note that I had been anxious before the interview, as the participant was a voluntary board member. I wondered whether she seemed both powerful and unknown to me and outside my own professional dialogue and comfort zone. I noted afterwards that I had spent time "educating" (also a professional dialogue of my own but not one necessarily relevant to the research). I was shocked to hear my own stance when listening to the audio recording and shocked by the high level of my own interventions, as these were markedly more frequent than in other interviews. This interviewee's comment at the end when the recorder had been switched off was: "How did I do?" She also, after the recorder was switched off, made reference to her awards as 'my award' meaning a national honour. These reflections by the interviewee helped me to disentangle my own anxiety from a countertransference anxiety of this participant. It raised the question early on in the interviews about how the anxiety of participants would affect their contribution and how my own would also play a significant part. The realisation that my own sense of position in terms of power was so influential in my responses in this particular interview led me to consider power in the discussion of the analysis as a key contribution to the

conclusions around the research question about containment and raised a further question. How related is containment to power?

A different perspective on power came from field notes on my countertransference in another interview, this time with a senior clinician. I think my own anxiety was alive in this interview, particularly because I arrived later than the time the interviewee had arrived for the interview. I had the sense of being wrong footed from the start. The interviewee was able to speak without pause for about fifteen minutes, one of the longest periods of any of the interviews. He started, I felt, by implying a criticism, Interview 13: "Quite a lot of the information was missing" and, "So I can't compute, based on the information presented". This was followed later by: "The second thing I dislike about these presentations is when there is...", and then: "There's a secrecy and lack of connection between psychotherapy notes and the general psychiatry notes that's problematic". As this interview progressed, without intervention from me, the emphasis shifted to experience: "I had the experience of looking after ten women over ten years", and, "As the ladies got older, they became less intense in their relationships and less intense in their reaction to relationships". My sense of being incompetent and then an older, inferior, woman grew during the interview. After the recorder was switched off my own feelings changed as, apparently, did those of the interviewee. He was now praising the assessment and said that he had treated it in the interview as he would treat a junior doctor. He said he had enjoyed the interview. The contrast though was stark and I felt that there was an element of sexism in the interview and a professional superiority, which then perhaps prompted some guilt that was expressed after the recorder had been switched off. The power relation seemed to be identified with gender and professional superiority and perhaps some

sadism linked to a projection of fear of being unable to have all the answers. My own countertransference was of a feeling of anger, as if containment was a battle rather than a reciprocal process, although this was hinted at.

I recorded in the field notes that many people spoke about having enjoyed the interview process: this was not specific to particular groups. The enjoyment statements came from managers and clinicians. One person stopped me in a corridor saying how much they had enjoyed the interview. Another person said, (post recording in Interview 17: Clinician: Female) that the interview had been a real rest from her normal day and that it was talking about a patient like we used to do. I was also aware that I had enjoyed the interviews too and that they had been powerful emotional experiences. Reflecting on what this enjoyment was about my feeling was that talking to a psychotherapist, for some people, felt like a glimpse into a world that they were curious about, not only curious about though, perhaps also mistrustful of to some extent and, in a few cases, openly resentful towards. However overall, I thought that the opportunity to listen to and speak about personal responses to the assessment of a person diagnosed with personality disorder was welcomed. Of course this was likely, as people had volunteered to participate in the research.

Some people, as with Interview 13 (Board member: Male) above, did seem to change their mind through the process of the interview. This was also the case with the person who had originally said there was no point in the research. Following this interview, the participant asked for feedback to the Board from the research. My feeling was that the emotional shift that the interviews had prompted had been containing and interesting for the participants and that this meant that the research

had a containing function in itself. I also sustained and developed my interest throughout the process.

I felt that, in the interviews, people often needed to have my agreement to their statements. There were some people who expressed hopelessness. One interview was with a participant who was imminently leaving the Trust. In this interview (Interview 19: Clinician: Female), the interviewee expressed serious and personal views which were critical of the Trust as an organisation and she was, I think, anxious to let me know without feeling that I might disagree or take the opposing side of defending the organisation. Another interviewee (Interview 20: Clinician, Female) very noticeably seemed to find talking much easier when the recorder was turned off; the recorder representing something of a potentially critical agency. The sense that thinking freely, free-associating and personal views could be dangerous seemed to be present. I felt positioned as a superficial ally who might turn critical. In a psychoanalytic sense, primitive paranoid schizoid feelings were not far away.

6.4 Supervision, Learning Sets and the Views of Others

I sought the views of the transcribers after the interviews were finished in order to get a wider view of the interviews from people who had a lot of experience. Comments were: "I thought the structure was good, they were free flowing, and the content was very interesting", and, from a different transcriber:

The style compares favourably with other work that we undertake, although the majority of our files are typed on an intelligent basis. We find full verbatim

transcription can be challenging at times, especially when the interviewees constantly hesitate. Re content, it was interesting to hear how each individual's thought process differed regarding the subject matter, and I thought that some very valuable and useful comments came out of the discussions

(Helen, Devon Transcription Service, 2015).

The role of supervision, working with groups of colleagues in academic learning sets and within NHS structures was crucial to the development of the research and to the development of my own ideas. Three main discussion groups have been used: a learning set group composed of two peer researchers and a supervisor; the NHS supervisory workshops and groups composed of psychotherapy colleagues and a medical psychotherapist and individual clinical supervision from a psychoanalyst. My own thinking about the research has also been assisted by my teaching role with junior doctors in the NHS. This can constantly challenge and refresh psychoanalytic ideas for me and was a forum to which I took for discussion an early presentation of the idea of containment used in the research.

I used individual supervision with a psychoanalyst to explore current clinical work and, for this research, this was key at the time of developing the initial research idea and questions and then particularly around the time of the assessments and the completed suicide. The assessment used for the interviews was discussed with this supervisor, as well as at the NHS assessment workshop. Both individual supervision and the workshop helped me to keep psychoanalytic thinking about disturbance to the fore. I felt that there was a high level of anxiety in the patient, and a rich and

terrifying world of dreams, hallucinations and voices. There was also a sense of abandonment and rage about the abandonment. The patient wore dark glasses throughout the assessment and there was both a sense of keeping in control of what can be understood and known and of keeping me away. Contact seemed to be felt as very concrete and frightening, rather like her description of her rape. What, I wonder in supervision, has this person lost. The patient talks of wanting to be inside a box of tissues, that is the only safe place. Thinking about this the box of tissues does represent safety for the patient and in that sense a place of containment but everything outside the box is terrifying and so containment is an impoverished concept for her, which excludes much of life. In psychoanalytic terms it is a retreat (Steiner, 1993). I feel that I am taking into the research a perhaps dramatic example of a patient with a diagnosis of borderline personality disorder. I feel interested in the visual quality of what she talks about and what this will mean for her psychotherapy. Will the concrete nature of her inner world help or hinder the process of her psychotherapy? I think at this point that it may make the research easier. It is engaging in a dramatic sense but will that, I wonder, impair further thinking and reflection. Will people go along with her impoverished idea of containment in a soft safe place or will they be more adventurous in their responses? I also wonder what will become of the patient. I am very aware of the one suicide. What will the research be like if there is another which is always a risk with this group? How ethical would I feel about the research then?

I have been able to keep track of the patient, at the point of writing up, who remains in therapy and to use a statement that they made themselves in the final conclusion of this thesis. This I think has helped me to write and complete the research. It is not

that there is a success but that there is ongoing work, there is something to build on with the research (Eco, 2015).

The feeling that I have kept about the research is that I need to always work out of my own comfort zone, building on what is available to me. This, to me, expresses the idea that disturbance is essential to learning and to growth and to the research, it fits with ideas of psychoanalytic work and Bion's concept of containment and with the development of reflexivity and its influence on the research.

The involvement of supervisors and colleagues in this is a check. There are regular meetings, which enable checking of the assessment, the method, the analysis and the reflexivity. It is subjectivity within a frame and meets Hollway and Jefferson's concern (2013) that subjectivity must be checked.

6.5 The Influence of Reflexivity

Three main features emerge from this chapter on reflexivity that influence the research, the data analysis, the discussion and conclusion. The first is the focus on death, suicide and self-harm in the analysis of data. This topic for analysis is relevant to the research questions but was highlighted by the reflexive approach. Secondly the sense in the field notes of the significance of power throughout the interviews, which seemed to be stronger in the reflexivity and countertransference than is shown in the analysis of the discourse itself. The significance of power contributes to the discussion and conclusions from the research. Thirdly the sense of enjoyment expressed by participants in the part of the interviews that followed the recorded time

is used in the discussion and conclusion to this thesis as a factor in the sense of containment that can be offered by two minds rather than one.

7

Discussion

What psychoanalytic containment do staff of the institution provide for a person with a diagnosis of personality disorder? (Question 1) This was the main question for the research. The question was investigated using detailed questions:

- 1a) How do staff talk about themselves in relation to the assessment of a person with a diagnosis of personality disorder?
- 1b) How do staff talk about self-harm, suicide, annihilation and death in this context?
- 1c) How are psychoanalytically defined defences employed to avoid and defend against the psychoanalytic idea of containment?
2. How does reflexivity concerning the research process develop the idea of containment?
3. What are possible future developments for the organisation in terms of improving containment?

This chapter will discuss the three main axes of this thesis, reflexivity, the findings from the literature review and the analysis of the interviews in the light of their relevance to the first three detailed questions and to answer questions 2 and 3. The conclusion concerning the overall question 1 about whether containment is currently provided or not for someone with a diagnosis of personality disorder is to be found in the next chapter.

The discussion follows a psychoanalytic approach to knowledge and understanding which has been described by Bell and Leite (2016) in a paper called, “Experiential self-understanding”, and is social constructionist:

A certain degree of ‘psychic distance’ is involved in being able to speak from one’s perspective while experiencing it as the perspective that it is. This isn’t the distance that arises from a third-personal relation of observation, inference, or reportage, however, nor is it dissociative or a split between an ‘I’ that is observing and a ‘me’ that is being observed. It is rather the distance that appears when one is not immersed in a perspective to such a totalizing extent that it becomes entirely transparent, an invisible lens through which one experiences the world, other people, and oneself. To continue the metaphor: it is like seeing a lens while you see through it. Plausibly, a crucial part of what enables this distance is the ability to express one’s perspective by naming it verbally or in thought. If a person cannot at all name her perspective, whether verbally or in thought, then it cannot show up for her as her perspective, but instead will simply be experienced as how the world itself is

(Bell and Leite, 2016, p.23-24).

The discussion takes a reflexive approach to the research, in the sense of an attempt at experiential self- understanding. It is written in the first person to highlight this. As Gergen states:

It seems to me that in a mature field of discourse study, the analyst would not

terminate discussion with the empirical account itself. Rather, there would be included a “moment of self-reflection,” in which the contingent character of the analysis would be made clear

(Gergen, 2014, p. 210).

I dream the night before trying to write this section of the thesis about arguing with a colleague about what I really enjoy. In the dream what I really enjoy is processing feelings, thinking and writing about the patient. I have to argue this firmly in the dream, to hold and reinforce my position of expressing my own view, and I have to resist someone who appears to want me to take notes, thereby only recording the views of others. In the dream I am successful in this argument. I remember on waking that Shelley, the subject of the original assessment used in the research, has recently written her own comment on her therapy programme. This experience, whatever the other personal constructions are in the dream, has the, “ Reverberative qualities” (Taylor, 2012, p.14), mentioned in the reflexive chapter of this thesis. Taylor’s reverberation is part of a dynamic iterative process, which involves representation and is about the psychoanalytic concept of containment.

Following that experience I take phrases from Shelley’s statement, made eighteen months after the initial assessment, as starting points for this discussion. The period of time that has elapsed for Shelley is the same as the period between starting the research and finishing the writing up. Shelley’s full statement can be found in Appendix S.

7.1 How Do Staff Talk about Themselves in Relation to the Assessment?

Reflecting on this I think that Shelley's, " 'Speaking' from someone", expresses both her fragmentation of her sense of "I" and is a way in which she is trying to deal with a disturbing idea. The disturbing idea in her statement is revisiting a place which she describes as, "Raw". She is, in psychoanalytic terms, splitting herself into different parts. There is a 'speaker' who is differentiated from the text by the quotation marks and a ' someone' who is anonymous. I seem to be considering a similar process in my own dream. Can I write something from a position that I can defend without distancing myself from the material or positioning myself as a note-taker with someone else's views? One difference is that I am dreaming a dilemma between selves, representing it, and Shelley is writing it as a statement.

The question of how people position themselves in relation to disturbance is the first detailed question of this research. From the literature review it is clear that few people have researched this with the exception of Bodner, Cohen-Fridel et al., (2015) and Holmqvist and Armelius, (2006). Some qualitative research and expert papers have focused on the way in which staff teams can be split and identified this as something that can affect the treatment of people with personality disorder adversely (Holmqvist and Armelius, 2006). In some expert papers (Johnston and Paley, 2013 and Thorndycraft and McCabe, 2008) which discuss reflective groups, the idea that staff attitudes can be explored and considered in a reflexive way is proposed. None of the papers reviewed examined a process by which people

position themselves with regard to the disturbance presented by people diagnosed with personality disorder. The paper analysing countertransference (Betan et al., 2005) did identify eight dimensions (see Section 2.3.2.3) and this comes closest to demonstrating attitudes that could be expressions of different positions. No papers considered that discourse analysis might be a way of trying to identify splitting or avoidance of disturbance.

The themes from the literature review (see Section 2.4 and Table 1) emphasise that people report negative attitudes to people diagnosed with personality disorder and the theme of negative attitudes, difficulty and stress is the only theme to be found in all four types of research. Research into the process of having, managing and expressing negative attitudes is limited to the two studies quoted above (Holmqvist and Armelius, 2006 and Betan et al., 2005).

The method of analysis of the interviews in this research focused initially on identifying positions and intertextuality. There were some common ways of doing this. Identifying with, "We", as a professional group was one way, often positioning the interviewee as powerful in respect of the patient and powerless in respect of the organisation or society. Interview 13 (Board member, Male): "I mean we've always admitted people with these, kind of, difficulties to wards, because we can't help ourselves, and society requires that we do it". This stance, as noted in the analysis, was also about both recognition of, and perhaps superiority to, the researcher. Some people positioned themselves as theoreticians, using concepts and generalisations

to describe the patient's experience. The stance taken sometimes implied a conflict between a personal and professional self. For example, in Interview 20 (Clinician, Female): "You just feel like you want to help the patient more... but you're not...you don't want to do it in the wrong way". This acknowledgement of fear was also present in some interviews as was the idea that this impaired a more thought through response.

Interest and curiosity and an openness to disturbance without any obvious positioning were rare. In one interview, Interview 4 (Clinician, Male):

Where I started was in quite a dark place about her, rather feeling myself to be overwhelmed and unable for it- and I feel less like that now, having talked about it and got inside the material a bit more. It is hard work with her.

Intertextuality was common and the main discourses utilised were professional psychiatric, psychoanalytic, psychological and managerial. The mechanism of, " 'Speaking' from someone", is prevalent in the interviews and may reflect the findings of the literature review concerning the dominance of negative attitudes to people diagnosed with personality disorder. A distancing is common.

7.2 How do Staff Talk About Suicide, Annihilation and Death in this Context?

Shelley is in touch with her own disturbance. She uses the phrase, “I feel I am sinking”, before writing, “ Increased delusions, disturbing images, nightmares and self-hatred, self-harm. My voices are relentless, telling me to do damaging/negative things”. Shelley states that she feels rejected and abandoned and that no one can reassure her of the future.

For me this resonates, although in a less intense way, to the period in the research which I have written about in the chapter on reflexivity, a hard time when there had been the suicide of one possible participant in the research. The question then was about my future as a researcher and the subject of the research. Would that all be destroyed and was there a future? This needed working through by me and with supervisors and colleagues.

In the literature review the theme of hopelessness was evident in both the meta syntheses and other research papers. One theme identified from O’Key and Das Nair’s (2014) meta synthesis of qualitative studies was, unreciprocated efforts and hopelessness. One of the themes from Betan et al.’s quantitative study (2005) was helpless/inadequate. In all ten qualitative studies the theme of unreciprocated effort and hopelessness was present (see Section 2.3.3.3). It is only in the expert papers that the bearing of disturbance is linked to the psychoanalytic concept of containment. Johnston and Paley (2013, p.45) write about the purpose of reflective groups: “To try to allow a more discomforting identification to allow more difficult

feelings to emerge". One paper confronts the topic of dealing with disturbance in a different way (Bodner, Cohen-Fridel et al., 2015). Bodner, Shrira et al., (2015) report on a brief quantitative questionnaire to Israeli psychiatrists, which showed that the psychiatrists' fear of death greatly contributed to negative emotions towards people diagnosed with personality disorder. This minimal piece of research could indicate that uncontained fears and disturbance in staff interfere with treatment.

Most of the qualitative studies (see Section 2.3.3.3) referred to staff feeling threatened, often this was in relation to the threat of suicide but sometimes in relation to aggression. Woollaston and Hixenbaugh (2008, p.705) record how a member of staff reported that a patient went berserk and left the member of staff shaking and crying. Feeling under threat was a theme for the meta-syntheses, quantitative and qualitative studies. In the expert papers disturbance was acknowledged as a theme and referred to within the context of some form of containment, mainly psychoanalytic, as a solution.

In the analysis of the interviews not everyone referred to death, suicide or risk, although this was mentioned in the assessment. Possibly some people unconsciously or consciously avoided talking about these topics. When suicide was mentioned there were people who positioned themselves as those who understood the process needed to contain suicidal ideas. Interview 10 (Senior clinician, Female): "They simply cannot manage their own states of mind in one mind. They need two". Another interviewee acknowledged both how hard it was to experience the

disturbance but also how being blind to it could be detrimental and result in an exacerbation of the suicidal idea. In Interview 3 (Senior clinician, Male): “ I, fear that if I am, if I am oblivious to her cutting , she will cut deeper so that I am not blinded to it...and it could go very deep”. This acknowledges a dynamic, a communicative danger of avoiding rather than processing a projection.

Some interviewees took a stance of distance from suicide or death. Talking of maintaining a distance and sending people into a physically safer environment like a ward was defined by one interviewee (Interview 18: Senior clinician, Female) as: “It’s a fear of people killing themselves and the blame culture that’s associated with that”.

In psychoanalytic terms this section showed how staff, including myself, can operate in a paranoid schizoid place, where thinking, reflection and containment are severely diminished by primitive feelings, such as fear. The literature review findings acknowledge the extent of fear in working with people diagnosed with personality disorder as a theme in terms of staff’s experience.

7.3 How are Psychoanalytic Defences Employed to Avoid and Defend Against Containment?

Shelley knows her own paranoia: “I’m still very paranoid”. She is afraid that people or things are listening to her and doing detrimental things to her. In her statement it is strips on the carpet that were the location of her fear. One of the

feelings that I had to think about when there was a suicide by a possible participant was the concern that I was blamed. I had, as I said in Chapter 6, to argue and adjust some of the wording of the Root Cause Analysis report. Feelings of fear are of course familiar to people. Klein's view (see Section 1.4, page 19) is that such defences are only pathological if they are rigid and extreme.

Unprocessed feelings of fear and other paranoid schizoid states of mind run counter to a depressive position and a psychoanalytic idea of containment. They can be uncontainable feelings, one of which can be the fear of death, or nameless dread in Bion's terms, which are defended against with defences of the paranoid schizoid position (Section 1.4, page 24). The defences of the paranoid schizoid position, splitting, projective identification and idealisation were investigated, for the purposes of this research, in terms of how they were shown in the interviews.

The focus, in this section, will be on these defences and how they impede the process of psychoanalytic containment. This is in response to the third detailed question: how are psychoanalytically defined defences employed to avoid and defend against the psychoanalytic idea of containment?

In the introduction and the literature review there were references to the primitive defences used by staff when working with people diagnosed with personality disorder. It is certainly not a new idea (Menzies, 1960). The papers in the literature

review which identified primitive defences had their base in psychoanalytic theory. In the quantitative studies Holmqvist and Armelius (2006) and Betan et al., (2005) state how the countertransference in staff in terms of their acknowledged feelings can be either used to enhance or impede treatment. In the qualitative studies there is a focus on the experience of staff but only Nehls (2000) considers the way in which the shift to non-psychoanalytic settings has meant that the idea of the containment of destructive feelings and impulses in the psychoanalytic sense has been lost and that this needs redressing. The expert papers all focus on how to address the primitive defences aroused by people diagnosed with personality disorder. Some (Kapur, 2008 and Evans, 1998) quote the older studies by Menzies (1960) and Main (1957). The conclusions of all the expert papers mainly focus on the benefits of training, supervision and reflective groups as ways of containing the primitive defences and disturbance in staff.

It is a noticeable omission that no papers (with the exception of Evans, 2014) seem to include the wider, senior management and administrative structure of organisations in these recommendations for containing primitive defences and disturbance.

In the analysis of the interviews splitting was evident in various ways: some interviewees divided themselves from the institution and some noted a split between the personal and professional selves. "There's a real dissonance between what's

known and what's felt" (Interview 18: Senior clinician, Female). There is also a split noted between professions: "There's a secrecy and lack of connection between psychotherapy notes and the general psychiatry notes that's problematic". Some people recognised this as a split within the Trust: (Interview 18: Senior clinician, Female): "There is in the Trust, a divide".

Projective identification and projection were evident in many interviews. The main themes of the projections identified in the analysis were influences on behaviour such as eating; the good interviewer who knew and understood things and sometimes was powerful and the bad management who did not; the ignorant interviewer who knew nothing and the seniors who held the knowledge and understanding. There were also frequent projections into the patient group. "They don't have a vocabulary", was one example in Interview 12 (Senior clinician, Female). This may have reflected the interviewees difficulty in finding their own language with which to speak about disturbance.

Idealisation was most prevalent in the interviews as an idealisation of cure and safety (see Section 5.3). This, when it has the fixed quality of a primitive defence, means that neither staff nor service users can think about responsibility or the disturbance. No processing of the feelings, in terms of containment can happen. Idealisation was also located in psychotherapy sometimes whilst others were denigrating (Interviews 1, 7 and 6, see Section 5.3).

Primitive defences in operation mean that without self-reflexivity or the opportunity to use another mind psychoanalytic containment cannot take place. Instead the staff or institution will be replicating and possibly exaggerating the primitive disturbance in the patient. There is also an additional concern, raised from the analysis of the interviews, reflexivity and the literature review (Evans, 2014) that the primitive defences of the organisation itself in terms of idealisation, splitting and projection combine to exaggerate power and control to an extent that containment of people diagnosed with personality disorder by staff is seriously interfered with. This echoes themes of the earlier papers referred to in Chapter 1, Section 1.6 (Hinshelwood, 2001, Nutkevitch, 2001, Menzies, 1960, Main, 1990 and Allcorn, 2008).

7.4 How does Reflexivity Concerning the Research Process Develop the Idea of Containment?

Shelley has an idea of shared experience, albeit 'secret': " We have an underlying 'secret' understanding of where we're coming from' ". There is a concept of understanding, which she seems to portray in her statement as something valuable. She makes the statement in relation to her experience of an analytic group. The statement may not be one that Shelley would have made at the time of her assessment. She understands now that there are others.

My own experience of this research is similar to that described as relational reflexivity by Hibbert, Sillince, Difenbach and Cunliffe (2014) in that: “Researchers also gain new alternative insights and the impetus to develop new variants and expressions of theory. For a relationally reflexive researcher, the theory-building process is iterative and developmental. Researchers grow and change alongside their theories” (Hibbert et al., p.30). They also make a comment which is similar to Bell’s (2016): “Like seeing a lens when you see through it”, quoted at the start of this chapter.

Both these papers suggest that an approach of reflexivity can be brought to the fore of research.

In the Introduction to this thesis a diagram of the process of containment was presented (Figure 1). The whole endeavour of the research has taken me through this process. In terms of my own development, I have understood and experienced disturbance and being able to represent that in my own self- understanding as well as with others and move on with researching and writing, also a continuous reflexive process (Lister, Kravis, Sandberg, Halpern, Cabaniss and Singer, 2008). When the writing is finished enough there will be a sense of limitation and depressive position containment. The process can always begin anew.

The only significant addition to the proposed theory of containment that I have felt, thought and noted in the summary at the end of the chapter on reflexivity comes from the experience of carrying out the research, analysing the data and my own reflexivity. It is the significance of the influence of power and control. The strength of power and control, in terms of working in opposition to the process of containment, emerged from triangulating my own experience, that of the process of undertaking the research and the analysis of the data. In Bion's terms this would be part of –K (minus K; K standing for knowledge), militating against knowledge, thinking, curiosity and containment. Power and control came to the fore as key primitive defences, which work against containment. Power and control evoke a feeling state of fear and powerlessness or rebellion in the countertransference. Throughout the interviews it seemed that a sense of power, or lack of it, would overwhelm the ability to process disturbance. This was expressed by projection and projective identification, both in the interviews and the comments afterwards. It was also expressed by the initial dismissal of the research itself from the top and bottom of the hierarchy of the organisation (see Section 6.2, page 181). I think this adds a dimension to thinking about containment and that it would be relevant to relationships with people who use services, staff and within the institution as a whole. Alongside (L) Love and (H) Hate (Bion, 1965), power and control, omnipotence or possession can interfere with the process of containment. If I had to give it a letter it would be P. This would be in addition to Bion's L and H (1965) and not to be confused with his use of Ps as an abbreviation of the paranoid schizoid position. In the original developmental theory of

containment there is a mother or primary caregiver. There is also a father. There is someone bigger and more able to think about feelings who need not be dominant or possessive. Dominance and possession are the aspects of power and control that can particularly impair thinking, reflecting and containment. Following the quotation from Kristeva at the opening of this thesis, instead it is a more intimate experience of pain that is required with a certain level of freedom and allowance for separateness.

7.5 What are Possible Future Developments for the Organisation in Terms of Improving Containment?

Shelley thinks that the strips on the carpet may be recording her words, “ I’m not sure if they are recording my words and using them in a detrimental way”. She remains paranoid.

Reading this just at the time I was writing the final section of this research her statement felt like a concern about the outcome of the research. Will the words be used in a developmental or detrimental way? It also made me aware of how using a single case study has an emotional power. A great deal of trust is implied in the NHS and University Ethics procedures. The permission is to use material; the ethical issue is about using the material well.

What is unexpectedly an outcome of the eighteen months since the field work started is that Shelley has more of a voice. She is able to write statements about herself and her treatment in way that she did not seem able to earlier. I have been able to use her words in this chapter.

Undertaking academic psychoanalytic research is a fairly new and perilous venture. There is only relatively recently beginning to be an academic field of study within universities in the UK. The venture in Exeter is six years old. I wondered if I would find a voice, which could make use of my psychoanalytic experience and knowledge and my understanding of research. I wondered also if the NHS Trust would pay attention to research from the psychoanalytic field that is non-positivist, qualitative and social constructionist.

There are possibilities for organisational development and the development of clinical practice, which would take more account of the relevance of the concept of containment for the treatment of people diagnosed with personality disorder. Some of these are already on agendas, such as reflective groups for staff and regular supervision and training and these have been proposed in other research. However, the psychoanalytic containment model does not seem to be widely accepted beyond psychoanalytically based services and neither does it seem to be reflected in strategic thinking such as recovery models. Some reporting models that propose action by staff without reflection can work against the psychoanalytic idea of

containment for both people who use services and staff. A failure of psychoanalytic containment could result in repeat admissions as escalation of disturbance.

The proposals for consideration from this research are:

1. That the organisation reflects on the way in which staff can be constricted in terms of their clinical reflective practice and capacity to contain service users by a fear of punishment.
2. That a process of encouraging and enhancing reflexive practice is developed as a whole organisation approach.
3. That a discussion of the psychoanalytic theory of containment is included in all staff training and potentially in psycho-educational groups for people who use services.

8

Conclusion

This section includes: an evaluation of the research; a reflection on method and a discussion of the limitations of this research. Suggestions are made for future research and for the dissemination of this research. An autobiographical comment is included. The conclusion to the overall question of the research is given in the final section.

8.1 Evaluation

Wood and Kroger's criteria (2000) adopted for my research (see Section 3.2, page 98) propose trustworthiness in terms of orderliness and clarity in the way in which the research is conducted, recorded and reported. The process of the research has to be described with sufficient clarity so that an external auditor can follow the trail.

For soundness the following criteria are proposed: demonstration, to show the argument through presenting the steps involved in the analysis of extracts rather than simply telling the reader about the argument; coherence of the set of analytical claims made about the discourse; plausibility in the sense of whether or not a set of claims is acceptable in the light of previous research and fruitfulness in terms of the

scope of analytic schemes to make sense of new kinds of discourse and to generate novel explanations.

In response to trustworthiness I have been explicit, both in the text and by use of appendices, about the conduct of the research. I have specified how the research was recorded and reported on the research by the use of reflexive writing and transcription and extensive quotation from the interviews.

In terms of soundness I have used referencing and quotation extensively to illuminate and develop my argument. It has been an iterative process informed by reflexivity which has been fully described. I have located the research within the context of a systematic literature review. The work has demonstrated a different way of looking, using psychoanalytic discourse analysis, at the psychoanalytic concept of containment and staff responses to someone with a diagnosis of personality disorder. There has been a contribution made to methodology, organisational and clinical practice and a contribution to knowledge of psychoanalytic containment as a subject.

1. The research has made a contribution to theoretical knowledge in terms of the addition of power over to the defences against containment .

2. The research has developed psychoanalytic discourse method in terms of the use of the analysis of discourse in relation to primitive defences and including reflexivity as central.

3. Recommendations to the organisation concerning staff constitute a contribution to clinical practice.

8.2 Limitations of this Research

In terms of methodology, this research is neither purely psychoanalytic or purely discursive psychology or psychoanalytic discourse analysis. As stated at the beginning of the literature review, it is cross disciplinary. The method is, as far as can be found at present, unique in its context. These are open interviews with free association to written text. This makes it vulnerable. The use of a single case means that, although the methodology could be replicated, the findings may not be.

The use of reflexivity in research is not well established in some fields of qualitative research. Whether this is seen as a strength or a weakness depends on how accepting readers are of subjectivity as worthy of a central place in research.

There is also the fact that the sample used was small (21) from an organisation employing thousands of staff. This could be a criticism and statements be made that the sample was unrepresentative and biased.

8.3 Reflection on Method

I have used a variation on existing psychoanalytic discourse analysis with reflexivity at the centre of the approach. Reflexivity emerged as more centre stage through the research process and enabled a closer working of psychoanalysis and discursive psychology. I chose certain aspects of several concepts of discursive psychology to use in the analysis which I felt were more suited to a psychoanalytic enquiry. The particular approach is innovative and develops a method which could be extended in terms of analysing discourse using aspects of discursive concepts with countertransference and reflexivity to investigate detailed psychoanalytic defences. The method also allows for exploration of the relationship between researcher and researched. This would provide a new method of psychoanalytic research.

In my research I used a single case study as a way of enabling different responses in the interviews to be seen more clearly. Whilst not valid in the sense that a quantitative study may be, this approach does allow differences to be highlighted. Although scenarios were used in previous research into staff reactions to people diagnosed with personality disorder (Adshead, 1998, Bodner, Cohen-Fridel et al., 2015, Evans, 1998, Steinberg and Cochrane, 2013) the method is unusual and innovative when used as it is in my research, across the hierarchy of an institution. In terms of eliciting different responses the single case study worked well.

8.4 Suggestions for Further Research

Further psychoanalytic discourse analysis could explore whether primitive and other defences are in other types of text from other contexts. This would investigate further how widely psychoanalytic thinking can be applied.

Qualitative research involving people with a diagnosis of personality disorder in an assessment of what is and is not a containing experience could be valuable for staff and for treatment programmes as a whole.

Organisational culture could be the focus of research into the effect of a top down target driven culture. This would follow on from the Francis Report findings.

The content of reflective groups and supervision sessions, particularly wider projective process, could be researched to discover how containing they are.

8.5 Dissemination of this research

Qualitative research using psychoanalytic ideas and a discursive approach may not easily fit into the reporting structures of the institution. It is possible however to open a dialogue about the ideas and the research itself. Two dissemination activities are being planned: one is a feedback meeting to all 21 participants in the

interviews. This does include a cross section in terms of the organisational hierarchy. The second is a written executive summary for circulation throughout the Trust via the central internet page. It should also be possible, as a third activity, to attend a Board meeting to present the findings. This was originally suggested at the time of the field work.

Two journal papers are planned: one focusing on methodology and one on the psychoanalytic containment of people diagnosed with personality disorder.

8.6 Autobiographical Comment

My reflexive learning from this research has been that my own experiences and feelings had a considerable impact on the analysis of the interviews as well as on the rest of the research project. This was particularly true of my emphasis, because of my reflections on the early suicide, on the question of how people talked about self-harm, suicide and death. As a consequence I placed this first in the data analysis. My own reflections on my countertransference to the interviews were significant in that they informed a triangular approach to deciding that the adverse influence of power and control on containment was the key addition to theory from this research. The other significant impact of reflexivity was in the use of my dream and the awareness of Shelley's statement at the point of writing the discussion. As Da Rocha Barros points out (Da Rocha Barros, 2011, p. 270) representation in

dreams can be understood as a first step towards 'thinkability'. The fact that I was able to use this statement by Shelley herself at this stage of the research seemed to reflect something of a parallel process or wider countertransferential field in terms of psychoanalytic containment.

8.7 Conclusion: What Psychoanalytic Containment do Staff of the Institution Provide for a Person Diagnosed with Personality Disorder?

There were 21 interviews undertaken for this research. They included interviews with people from all levels of the organisation and from a variety of contexts. It is arguably the case that only two interviewees showed a level of reflexivity that I would call containment in its full sense. Both these interviewees were experienced psychoanalytically orientated clinicians. Containment for them was a process of orientation, disturbance, representation of feeling and a depressive settling. They did use the interviewer as another mind to reflect with but also had a capacity to do this work in the free associative part of the interview. Others had aspects of containment interspersed in the interviews. Often people could orientate to the disturbance communicated in the assessment but then would position themselves at a distance from the disturbance by talking of others or taking a particular stance.

One simple conclusion would be that containment is not common at clinical levels of the organisation, and less so in non-clinical levels. Perhaps this is because it remains a hard task. It requires the bearing of disturbance itself, a painful process that many want to avoid. This idea of containment is, as stated in Chapter 1, not limited to Bion's psychoanalytic theory but is common to other theories. As Knox states in her paper (2016), "Mentalizing means to allow ourselves to know what abuse feels like from the inside. And that is hard – very hard" (Knox, 2016, p.235).

There is a tendency to provide relief, a place of safety or reassurance instead. If the theory of containment put forward in this thesis is accepted the consequence of failing to provide it would be that the disturbance of the service user would be repeated or exaggerated until it was better understood.

There were references in the memos from the interviews to people saying, after the recording had been switched off, that they enjoyed the experience of the interviews and in some interviews, for example Interview 18, the process of the interview moved through disturbance to distancing from the disturbance and then back to a positive sense of possibilities after the recording was switched off. The interview process itself could be described as containing. What is unclear is whether or not people would have identified this kind of enjoyment as containment. The phrase: "Talking about patients like we used to do" (Memo 18, Interview 18: Senior clinician,

Female), says something about the lack of reflective time available currently and the lack of knowledge of the theory of containment.

The main impediments to containment found in the research related to the primitive defences of splitting, idealisation and projection and projective identification. These defences combine into a version of power and control which staff, including myself, found interfered with their capacity to reflect and contain the powerful feelings of people diagnosed with personality disorder.

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<http://www.who.int/classifications/icd/en/GRNBOOK.pdf> Geneva: World Health Organization. Retrieved from the internet: 31-3-2016.

Appendices

Appendix A: Thames Valley Severity Index



Severity Questionnaire

These criteria are intended to assess the severity of PD across several practical domains, as defined in the 'Beyond Local Services' commissioning policy. It is not copyrighted, so anybody is free to use it if they find it useful. Thank you.

Name:	Date:	Total Score:
CareNotes No:		

PLEASE HIGHLIGHT THE SCORE FOR EACH OF THE FIVE ITEMS

0 = Absent **1 = Present (to moderate extent)** **2 = Present (to considerable extent)**

1. Diagnosis

There are ten Personality Disorders outlined in the DSM-IV (APA, 2000). These diagnoses are organised according to three clusters;

Cluster A – Odd/ Eccentric (Paranoid, Schizotypal, Schizoid)

Cluster B – Dramatic/ Emotional/ Erratic (Borderline, Histrionic, Narcissistic, Antisocial)

Cluster C – Anxious/ Fearful (Obsessive-Compulsive, Dependent, Avoidant)

0 = No formal diagnosis may have been made, or a single diagnosis or diagnoses present in only one cluster, not including ASPD. Equates to approximate IPDE screening tool score < 30.

1 = More than one PD diagnosis, probably in more than one cluster, unlikely to include ASPD. IPDE screening tool score approximately 30 – 50.

2 = Multiple PD diagnoses in more than one of the three clusters, and may include ASPD. IPDE screening tool score usually > 50.

2. Pervasiveness

If an individual is severely affected by PD, then this will be evident across many domains of life functioning: Relationships –intimate, familial, social

Activities of daily living eg. self-care, shopping, cleaning, home management, paying bills

Living conditions Occupation Education Social functioning

0 = Little significant impact on functioning, and normally able to function effectively eg. stable living arrangements, social participation, able to work, evidence of some good relationships

1 = Functioning moderately impaired; some evidence of adequate functioning but for short-lived periods of time eg. predominately dysfunctional relationships, frequent job changes/periods of unemployment, difficulties with daily living tasks,

2= Functioning is seriously impaired across many domains, and lifestyle is severely disrupted or never established eg. unstable/unsuitable living conditions, or homelessness, inability to establish and maintain relationships, social exclusion, unemployment, financial insecurity,

3. Complexity

Co-morbidity; Depression, Anxiety Disorders (PTSD, OCD, GAD), Eating disorders, Substance Misuse, Addictions, Learning Disabilities, Head Injury, Medication usage, Crisis Management

0= Little or no co-morbidity, although may have experienced previous mental health problems for time-limited periods, such as depression and anxiety. Will make some demands on mainstream health services. May occasionally require crisis intervention and prescription medication during times of stress.

1= One or more significant co-morbidities are present in addition to their personality disorders, such as an eating disorder, anxiety disorders, and possibly some use of alcohol or non-prescribed drugs. Will utilise crisis services and other specialist services, and demonstrate high dependency on them.

2 = A range of co-morbidities will exist and substance misuse is probable. Likely to have been prescribed a range of psychotropic medications for a number of years. High frequency and intensity service use will be evident, including hospitalisations and/or contact with the Criminal Justice System. Periodically in crisis. Will have previously received treatment for a number of years, but significant impairment and distress

4. Risk

Risk to Self – self harm and self-defeating behaviours, suicide

Risk to Others – violence, aggression, impulsivity, vulnerability, engagement, Child Protection

0 = Little or no risk of harm to self or others. May be vulnerable at times of stress.

1 = Vulnerable at all times and will pose a significant, variable risk to self, through self-harm, self-neglect, and impulsive risky behaviours. Unlikely to pose a threat to others, although may represent a significant burden to families, friends, and carers.

2 = Considerable and continual risk to self and others, through frequent impulsive behaviour and likely to demonstrate poor emotional regulation and behavioural control. If children are present at home, likely that they will be suffering emotional neglect, abuse, and/or detrimental parenting. Persistent and/or life threatening behaviours, including suicide attempts and chronic, serious incidents of self-harm. Probable engagement in risky and/or offending behaviour and hence a risk to others.

5. Unmanageability

Destructive behaviour unresponsive to attempts to reduce it; reluctance to engage in therapeutic relationships; seeks help in indirect and often counter-productive ways.

0 = Manageable without significant formal intervention/treatment. Support will be provided through family, community, and mainstream public services.

1 = Requires support and treatment from dedicated Tier 1 - Tier 3 specialist and PD services. May have received intensive treatment at some point previously.

2 = Experienced by many services as unmanageable and demonstrates continuous involvement with health, justice and other statutory services. Previous recurrent failures to engage or respond to treatment. Difficult to successfully manage and safely contain in community services, and will frequently present to crisis and emergency services. Likely to have a specific need for residential treatment. May have previously been in prison or secure units, or currently at risk of moving into these settings for low level offences.

Appendix B: Bion's Grid

	Definitory Hypotheses	$[\psi]$	Notation	Attention	Inquiry	Action	
	1	2	3	4	5	6	... n.
A β -elements	A1	A2				A6	
B α -elements	B1	B2	B3	B4	B5	B6	... Bn
C Dream Thoughts Dreams, Myths	C1	C2	C3	C4	C5	C6	... Cn
D Pre-conception	D1	D2	D3	D4	D5	D6	... Dn
E Conception	E1	E2	E3	E4	E5	E6	... En
F Concept	F1	F2	F3	F4	F5	F6	... Fn
G Scientific Deductive System		G2					
H Algebraic Calculus							

From Bion, W. (1962) *Learning from experience*, p.106. London: Tavistock.

Appendix C: CASP Systematic Review Checklist

1. Did the review address a clearly focused question?
2. Did the authors look for the right type of papers?
3. Do you think all the important relevant studies were included?
4. Did the authors do enough to assess the quality of the included studies?
5. If the results have been combined was it reasonable to do so?
6. What are the overall results of the review?
7. How precise are the results?
8. Can the results be applied to the local population?
9. Were all important outcomes considered?
10. Are the benefits worth the harms and costs?

CASP (Critical Skills Appraisal Programme), 30-05-2013.
Retrieved from the internet: 25-04-2016.

Appendix D: CASP Qualitative Checklist

1. Was there a clear statement of the aims of the research?
2. Is a qualitative method appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

Critical Appraisal Skills Programme (CASP) Qualitative Checklist, 30-05-2013.
Retrieved from the internet: 25-4-2016.

Appendix E: Effective Public Health Practice Project (EPHPP) Quality Assessment Tool for Quantitative Studies

Ratings are: 1 = Strong, 2 = Moderate, 3 = Weak.

Component Ratings

- a) Selection bias
- b) Study design
- c) Confounders
- d) Blinding
- e) Data collection methods
- f) Withdrawals and dropouts
- g) Intervention integrity
- h) Analyses

Global Rating

Effective Public Health Practice Project (EPHPP) Quality Assessment Tool for Quantitative Studies.

Retrieved from the internet: 25-04-2016.

Appendix F: Variation on CASP Qualitative Checklist for Expert Papers

1. Was there a clear statement of the aims of the paper/research?
2. Is the method appropriate?
3. Was the design appropriate to address the aims of the paper/research?
4. Was there a recruitment strategy appropriate to the aims of the paper/research?
5. Was the data collected in a way that addressed the key issues?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings and/or recommendations?
10. How valuable is the research?

Critical Appraisal Skills Programme (CASP) Checklist Adaptation by E. Weightman.
01-02-2016.

Appendix G: CERqual Meta-synthesis Review Assessment Tool**Component Definition**

Component	Definitions
Methodological	The extent to which there are problems in the design or conduct of the primary studies that contributed evidence to a review finding
Limitations	
Relevance	The extent to which the body of evidence from the primary studies supporting a review finding is applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question
Coherence	The extent to which the review finding is well grounded in data from the contributing primary studies and provides a convincing explanation for the patterns found in these data
Adequacy of data	An overall determination of the degree of richness and quantity of data supporting a review finding

CERqual (Confidence in the evidence from reviews of qualitative research).
PlosMedicine. DOI:10.1371/journal.pmed.1001895.t001
Retrieved from the internet 25-04-2016.

Appendix H: Full Search Strategy

Search History 2014

-
1. PsycINFO; exp PERSONALITY DISORDERS/; 21168 results.
 2. PsycINFO; PSYCHIATRIC HOSPITALS/ OR PSYCHIATRIC UNITS/; 8377 results.
 3. PsycINFO; (contain* OR boundar*).af; 194655 results.
 4. PsycINFO; exp PSYCHOTHERAPY/ OR exp PSYCHOTHERAPEUTIC TECHNIQUES/ OR exp COGNITIVE BEHAVIOR THERAPY/ OR exp BEHAVIOR THERAPY/ OR exp PSYCHOLOGY/; 310654 results.
 5. PsycINFO; psychoanaly*.af; 151899 results.
 6. PsycINFO; 1 AND 2 AND 3; 11 results.
 7. PsycINFO; emotional.af; 378582 results.
 8. PsycINFO; 4 OR 5 OR 7; 710843 results.
 9. PsycINFO; 1 AND 2 AND 8; 44 results.
 10. PsycINFO; 6 [Limit to: English Language]; 10 results.
 11. PsycINFO; 9 [Limit to: English Language]; 35 results.
 12. MEDLINE; exp PERSONALITY DISORDERS/; 31441 results.
 13. MEDLINE; HOSPITALS, PSYCHIATRIC/; 22339 results. 14. MEDLINE; (contain* OR boundar*).af; 1248877 results.
 15. MEDLINE; 12 AND 13 AND 14; 14 results.
 16. MEDLINE; 15 [Limit to: English Language]; 13 results.
 17. MEDLINE; PSYCHOANALYTIC INTERPRETATION/ OR PSYCHOLOGICAL TECHNIQUES/ OR "IMAGERY (PSYCHOTHERAPY)"/ OR MUSIC THERAPY/ OR NARRATIVE THERAPY/ OR NONDIRECTIVE THERAPY/ OR PSYCHOTHERAPY, BRIEF/ OR PSYCHOTHERAPY, MULTIPLE/ OR PSYCHOTHERAPY, PSYCHODYNAMIC/ OR PSYCHOTHERAPY, RATIONAL-EMOTIVE/ OR REALITY THERAPY/ OR SOCIOENVIRONMENTAL THERAPY/ OR exp PSYCHOTHERAPY/ OR exp BEHAVIOR THERAPY/ OR exp FEEDBACK, PSYCHOLOGICAL/ OR exp PSYCHOANALYTIC THERAPY/ OR exp PSYCHOTHERAPEUTIC PROCESSES/ [Limit to: English Language]; 128086 results.
 18. MEDLINE; 12 AND 13 AND 17 [Limit to: English Language]; 112 results.

19. MEDLINE; institution*.af [Limit to: English Language]; 188430 results.
20. MEDLINE; 12 AND 14 AND 17 AND 19 [Limit to: English Language]; 7 results.
21. PsycINFO; institution*.af; 176623 results.
22. PsycINFO; 1 AND 3 AND 8 AND 21; 48 results.
23. PsycINFO; 22 [Limit to: English Language]; 44 results.
24. PsycINFO; 22 [Limit to: English Language]; 44 results.
25. CINAHL; "personality disorder".af; 9365 results.
26. CINAHL; (hospital* OR institution* OR "psychiatric unit*" OR "secure setting*" OR "secure unit*").af; 773697 results.
27. CINAHL; (contain* OR boundar*).af; 183773 results.
28. CINAHL; (psychoth* OR psycholog* OR psychoanaly* OR emotional OR therap*).af; 1194420 results.
29. CINAHL; 25 AND 26 AND 27 AND 28; 1811 results.
30. CINAHL; 29 [Limit to: (Language English)]; 1810 results.
31. CINAHL; (contain* OR boundar*).ti,ab [Limit to: (Language English)]; 37575 results.
32. CINAHL; 30 AND 31 [Limit to: (Language English)]; 102 results.

Search History 2015

1. PsycINFO; exp PERSONALITY DISORDERS/; 21168 results.
2. PsycINFO; PSYCHIATRIC HOSPITALS/ OR PSYCHIATRIC UNITS/; 8377 results.
3. PsycINFO; (contain* OR boundar*).af; 194655 results.
4. PsycINFO; exp PSYCHOTHERAPY/ OR exp PSYCHOTHERAPEUTIC TECHNIQUES/ OR exp COGNITIVE BEHAVIOR THERAPY/ OR exp BEHAVIOR THERAPY/ OR exp PSYCHOLOGY/; 310654 results.
5. PsycINFO; psychoanaly*.af; 151899 results.
6. PsycINFO; 1 AND 2 AND 3; 11 results.
7. PsycINFO; emotional.af; 378582 results.

8. PsycINFO; 4 OR 5 OR 7; 710843 results.
9. PsycINFO; 1 AND 2 AND 8; 44 results.
10. PsycINFO; 6 [Limit to: English Language]; 10 results.
11. PsycINFO; 9 [Limit to: English Language]; 35 results.
12. MEDLINE; exp PERSONALITY DISORDERS/; 31441 results.
13. MEDLINE; HOSPITALS, PSYCHIATRIC/; 22339 results.
14. MEDLINE; (contain* OR boundar*).af; 1248877 results.
15. MEDLINE; 12 AND 13 AND 14; 14 results.
16. MEDLINE; 15 [Limit to: English Language]; 13 results.
17. MEDLINE; PSYCHOANALYTIC INTERPRETATION/ OR PSYCHOLOGICAL TECHNIQUES/ OR "IMAGERY (PSYCHOTHERAPY)"/ OR MUSIC THERAPY/ OR NARRATIVE THERAPY/ OR NONDIRECTIVE THERAPY/ OR PSYCHOTHERAPY, BRIEF/ OR PSYCHOTHERAPY, MULTIPLE/ OR PSYCHOTHERAPY, PSYCHODYNAMIC/ OR PSYCHOTHERAPY, RATIONAL-EMOTIVE/ OR REALITY THERAPY/ OR SOCIOENVIRONMENTAL THERAPY/ OR exp PSYCHOTHERAPY/ OR exp BEHAVIOR THERAPY/ OR exp FEEDBACK, PSYCHOLOGICAL/ OR exp PSYCHOANALYTIC THERAPY/ OR exp PSYCHOTHERAPEUTIC PROCESSES/ [Limit to: English Language]; 128086 results.
18. MEDLINE; 12 AND 13 AND 17 [Limit to: English Language]; 112 results.
19. MEDLINE; institution*.af [Limit to: English Language]; 188430 results.
20. MEDLINE; 12 AND 14 AND 17 AND 19 [Limit to: English Language]; 7 results.
21. PsycINFO; institution*.af; 176623 results.
22. PsycINFO; 1 AND 3 AND 8 AND 21; 48 results.
23. PsycINFO; 22 [Limit to: English Language]; 44 results.
24. PsycINFO; 22 [Limit to: English Language]; 44 results.
25. CINAHL; "personality disorder*".af; 9365 results.
26. CINAHL; (hospital* OR institution* OR "psychiatric unit*" OR "secure setting*"

OR "secure unit*").af; 773697 results.

27. CINAHL; (contain* OR boundar*).af; 183773 results.

28. CINAHL; (psychoth* OR psycholog* OR psychoanaly* OR emotional OR therap*).af; 1194420 results.

29. CINAHL; 25 AND 26 AND 27 AND 28; 1811 results.

30. CINAHL; 29 [Limit to: (Language English)]; 1810 results.

31. CINAHL; (contain* OR boundar*).ti,ab [Limit to: (Language English)]; 37575 results.

32. CINAHL; 30 AND 31 [Limit to: (Language English)]; 102 results.

In addition, Social Care Online was searched using terms:

AllFields:"personality disorder"

- AND AllFields:'containment or boundary or boundaries'

- AND AllFields:'psychiatric hospital or institution'

- AND AllFields:'psychological or psychology or psychotherapeutic or psychotherapy or emotional or psychoanalytic or psychoanalysis'.

Referencing software was used to de-duplicate all the above search results.

The first PEPweb search used the terms, "personality disorder" and "containment" and produced 338 results. The PEPweb search using "personality disorder" and "qualitative" produced 234 results. Both searches were restricted to 1998 – 2015.

Appendix I:

Table 1: A Summary of the Quality Appraisal of the 11 Quantitative Studies Using the EPHPP Tool (2006).

Table 2: A Summary of the Quality Appraisal of the 10 Qualitative Studies, Using the CASP Checklist (2013).

Table 3: A Summary of the Quality Appraisal of the Ten Expert Papers (adapted from CASP 2013)

Table 4: Summary of the Quality Appraisal of Three Meta Syntheses Using the Cerqual Tool (2016)

Table 1: A Summary of the Quality Appraisal of the 11 Quantitative Studies Using the EPHPP Tool (2006).

Key to Rating Scores: 1 = Strong, 2 = Moderate, 3 = Weak

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
Betan, E. 2005	Countertransference phenomena and personality pathology in clinical practice: An empirical investigation	To describe the factor structure and reliability of a broadband measure of countertransference phenomena and to examine associations between countertransference	Use of clinical data from, axis 11 diagnosis and countertransference questionnaire – not modality specific	Countertransference questionnaire had 79 items derived from thoughts, feelings and behaviours expressed by therapists towards their patients. Used established criteria (Kaiser) and scree plot to derive factors	Random national sample of experienced psychologists and psychiatrists from membership registers plus use of last patient seen as selected for responses	USA	Established a readily administered measure for countertransference responses to patients which could be used for future research. Eight countertransference dimensions found: overwhelmed/disorganised, helpless/inadequate, positive, special/overinvolve	2

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
		phenomena and patients' personality pathology		(eight)			d, sexualised, disengaged, parental/protective and criticised/mistreated. Identified similar countertransference responses to narcissistic personality disordered patients. Weak because no control group.	
Bodner, E. 2015	The attitudes of psychiatric hospital staff toward hospitalisation and treatment of patients with borderline personality disorder	To identify attitudes of staff to patients with borderline personality disorder	Questionnaires to staff from four mental health professionals: psychiatrists, nurses, psychologists & social workers	Three questionnaires – two measuring cognitive and emotional attitudes toward people with borderline personality disorder and one measuring attitudes to	Proportional volunteers (N= 710) sample of staff in geographic area in the four categories of staff: psychiatry, psychology, social work and nursing.	Israel	Nurses showed more negative cognitive attitudes and empathy to those with borderline personality disorder but not in comparison to psychiatrists. Attribution of negative traits were more prominent for a borderline	1

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
				people with borderline personality disorder and those with depressive or anxiety disorders with a short narrative.			personlity disordered patient than for a depressed patient. Nurses did not attribute more negative states to those with personality disorder than those with other disorders as opposed to other professions.	
Bodner, E. 2015	Psychiatrists fear of death is associated with negative emotions toward borderline personality disorder patients	Hypothesis was that psychiatrist s' fear of death would be posiitvely linked to negative attitudes toward borderline personality disorder patients	Emails explaining the study with link to a five minute internet questionna ire	Statistical analysis including Pearson correlations and hierarchical linear regresssions	12% of Israeli psychiatrists, graduates of all Israeli medical schools	Israel	Fear of death greatly contributed to negative emotions towards people with borderline personality disorder. Subjective nearness to death and suicide stigmatisation contributed to higher negative emotions towards	2

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
							those with borderline personality disorder.	
Cleary, M. 2002	Experience, knowledge and attitudes of mental health staff regarding clients with a borderline personality disorder	To survey the experience, knowledge and attitudes to staff working with clients with a diagnosis of borderline personality disorder and to provide direction for future education and training.	A 23 item questionnaire was developed and posted to community and hospital based mental health staff in an area mental health service	Data was analysed using SPSS and presented as simple frequencies and observed rates.	All staff (n=516) in an area mental health service. There was a 44% response rate.	Australia	Most staff (80%) said that dealing with clients with borderline personality disorder was more difficult than dealing with other groups. 95% of staff wanted further training of one hour a month. Findings suggest that there is considerable room for improvement in care for this group, a need for training and identified clinical supervision as key.	3

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
Deans, C. 2006	Attitudes of registered psychiatric nurses towards patients diagnosed with borderline personality disorder	To describe psychiatric nurses attitudes towards people diagnosed with borderline personality disorder	Questionnaire survey (used Little, 1999) with four sections: clinical description, emotional reactions, concerns, management.	Likert scale questionnaire responses analysed by SPSS using descriptive statistics to identify and describe attitudes towards patients with borderline personality disorder.	Convenience sample of 65 registered nurses employed in inpatient and community settings in one district.	Australia	A high proportion of staff experienced negative attitudes and emotions when caring for patients with borderline personality disorder with almost one third reporting that patients made them angry. 47% of respondents reported that they felt responsible for the safety of patients with borderline personality disorder. Need acknowledged for training, support and further research into nursing management.	3

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
Egan, S. 2014	Attitudes of clinical psychologists towards clients with personality disorders	Investigating the attitude of clinical psychologists to people with borderline personality disorder and looking at the importance of specific training	Cross sectional correlation design. Use of the Attitude to Personality Disorder Questionnaire (APDQ) which had already previously been used by Bowers, 2003.	Bivariate correlations were used to test the predicted relationships between variables along with a hierarchical regression analysis to examine how much variance in attitudes the hypothesised variables could account for.	Information distributed to all registered psychologists with an offer of reward. Online survey APDQ used. Respondents 81 completed (13 non completers). Should have been sample size of 85 to get medium effect.	Australia	Most significant predictor of positive attitude towards borderline personality disorder was the percentage of clients with this diagnosis on current caseloads. Training was associated with improved attitudes.	2
Forsyth, A. 2007	The effects of diagnosis and non-compliance attributions on therapeutic alliance processes in adult acute	Concerned with identifying whether mental health workers' cognitive processes	Utilised eight constructed and validated clinical vignettes and a 15 item rating	Three independent variables: diagnosis, stability attribution for negative event, controllability	All staff in a locality invited (120). No sampling procedure used. Response rate 22%.	UK	Demonstrated a tendency to show a relationship between attribution combinations of controllability and stability on anger, empathy and helping	3

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
	psychiatric settings	vary across clinical diagnoses for clients with either borderline personality disorder or major depressive disorder.	scale for helping, empathy and anger reactions.	attribution for negative event. Likert scale used to rate helping, empathy and anger (previously used scale, Burns & Nolen-Heksema, 1992). SPSS used. Descriptive statistics in the form of means produced across all independent variables.			behaviours. Clients perceived to have controllable and stable reasons for non completion of a therapy task received less empathy from health workers. Mental health workers showed more potential negative reactions to clients with a diagnosis of borderline personality disorder than towards depressed clients.	
Hayward, P. 2005	"The ailment" revisited: Are "manipulative" patients really the most difficult?	To investigate clusters of behaviours that mental health staff might find	Two studies, one rating 48 types of patient behaviour that staff	Likert scale was analysed with descriptive statistics and suggestions for coping.	All staff members of a mental health trust were circulated with the questionnaire	UK	The first study confirmed Main's portrait of the difficult and distressing patient and secondly confirmed the idea	2

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
		difficult and stressful.	might find difficult. The results were then clustered. Staff then rated seven patient vignettes for difficulty and distress together with coping strategies.	Questionnaires were analysed. For the second study vignettes were developed and checked and then presented with a Likert scale on level of distress and difficulty of working with.	s with a response rate of less than 50% after accounting for spoilt returns.		of a manipulative patient. The second study results showed that aggressive and self harming patients scored highest for difficulty and distress. They suggest both further research and further training for staff.	
Holmqvist, R. 2006	Sources of psychiatric staff members' feelings towards patients and treatment outcome	To assess to what extent habitual feeling style in staff, recurrent reactions to individual	Two instruments were used: Kernberg's structural interview (1975) to measure outcome and	The proportion of variance accounted for by each factor was analysed. The associations between the contributory	Naturalistic design. All staff and patients in the 21 units were included in the study.	Sweden	The patients evocative feelings had less importance than the differences between the staff members' feeling patterns. The analysis of relations with outcome found few	1

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
		patients (evocative patient pattern) and the interaction between them contributed to the total variance in staff members' feelings and if there were any associations between these contributions and the treatment outcome.	Holmqvist and Armelius' feeling checklist. Administered twice a year for five years.	factors and outcome was assessed on unit level (21).			correlations but suggested that higher proportions of variance in staff members' feelings were associated with worse outcome. Suggests that for borderline personality disorder splitting between staff is associated with worse outcomes. Also suggests that rigidity of feeling in therapists contributes to worse outcome and that flexibility in feeling in therapists contributes to positive outcomes.	

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
James, P. 2007	Psychiatric nurses' knowledge, experience and attitudes towards clients with borderline personality disorder	Attitudes towards services for people with a diagnosis of borderline personality disorder and attitudes towards caring for people with a diagnosis of borderline personality disorder,	Variation on Cleary (2002) questionnaire using a Likert scale with five sections: demographics, contacts with the patient group and view of services, rating statements on borderline personality disorder diagnosis, treatment, information about assessments and	Used SPSS to produce descriptive statistics.	Sample was of all nurses working in a clinical role at the study site. 41.4% participated.	Ireland	Themes reflected ideas of adequate care (60%) and staff perceived caring for those with borderline personality disorder as part of their role (80%). Less evidence of negative attitudes than in other studies. Staff did feel uncomfortable with the diagnosis but this was not investigated further. Asks for further qualitative research.	2

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
			ideas about difficulty and whether staff think they have a role in working with this group.					
Markham, D. 2003	The effects of the psychiatric label 'borderline personality disorder' on nursing staff's perceptions and causal attributions for challenging behaviours	To investigate how the label of borderline personality disorder affected staff's perceptions and attributions towards people diagnosed with borderline personality	Use of Attribution Style Questionnaire (Peterson et al, 1982) which uses scenarios. Completed for three different patients by each participant.	Used tests to assess differences between personality disorder and other disorders. Pearson correlations were used to assess the association between sympathy and control.	Nurses approached at staff meetings, all approached agreed to take part (50).	UK	Recommends use of qualitative methodology in future research. Supports the hypothesis that patients with a diagnosis of borderline personality disorder attract more negative responses from staff than those with other diagnoses. Staff attributions were higher for stability	1

First author and year	Title	Focus	Study design	Quantitative measures	Sample	Country	Analysis	Score
		disorder					and control dimensions than other conditions. Attributions of control reduced staff sympathy. Staff also reported less optimism towards patients with a diagnosis of borderline personality disorder.	

Table 2: A Summary of the Quality Appraisal of the 10 Qualitative Studies, Using the CASP Checklist (2013).**Score: 1 = Strong, 2 = Moderate, 3 = Weak.**

First Author	Title	Country	Research Aims	Sample	Design/Methodology	Reflexivity	Findings	Score
Bergman, B. 2000	Professional skills and frame of work organization in managing borderline personality disorder.	Sweden	To broaden the understanding of what it means for caregivers to manage borderline personality disorder patients.	N = 29 caregivers strategically selected and then volunteering : physicians, staff nurses, social counsellors and psychologists.	Interviews focusing on caregivers experiencing of managing borderline personality disorder patients with broadly focused questions which allowed for a conversational approach. These were carried out by experienced psychologists, noted and transcribed. Grounded theory was used to analyse the interviews.	No evidence	Two higher-order categories and eight sub categories: professional skills of mental health workers with empathy for persons with borderline personality disorder, interest in treating the disorder, feelings of professional frustration and need for common outlook as sub categories and frame of work organization with ambivalence between the professions of caregivers, need of structure in organising the work, forms of emotional support to the	2

First Author	Title	Country	Research Aims	Sample	Design/Methodology	Reflexivity	Findings	Score
							caregivers and shared philosophy and ethics of caring for borderline personality disorder.	
Crawford, M. 2010	Job satisfaction and burnout among staff working in community-based personality disorder services.	UK	To examine staff responses to working with people with personality disorder.	Mixed method study with distribution of questionnaires to all staff (73.7% return, n = 87) and then purposive sampling (n = 89) to ensure a mix of people with different experience and qualifications for the in-depth interviews. This	SPSS descriptive statistics were used to explore the characteristics of staff and the levels of burnout from the questionnaires. Transcriptions and field notes were used for the thematic analysis of the interviews.	Continuous review and reflection refining both the topic guide and the coding framework.	<ol style="list-style-type: none"> 1. Quantitative data suggested higher levels of personal accomplishment and lower levels of emotional exhaustion than have tended to be reported in previous surveys of staff working in general mental health service. 2. Qualitative data suggested staff had positive experiences 	2

First Author	Title	Country	Research Aims	Sample	Design/Methodology	Reflexivity	Findings	Score
				involved approaching staff from eleven services (8 participated).			of working with people with personality disorder. 3. Future research into the duration of low levels of burnout over time was suggested.	
Lee, A. 2014	'It's one of the hardest jobs in the world': The experience and understanding of qualified nurses who work with individuals diagnosed with both learning disability and	UK	To investigate the experiences of nurses working with those diagnosed with learning disability and personality disorder.	n = 9 Recruited via ward managers within units that were part of a personality disorder pathway.	Semi structured interview transcribed and then analysed by IPA method. Emergent themes were developed and a table of master themes was produced.	A reflexive log was kept and the analytic process was reviewed by the research team.	Master themes identified were: personality disorder overriding learning disability, resilience, ambivalence towards the label and knowledge.	1

First Author	Title	Country	Research Aims	Sample	Design/Methodology	Reflexivity	Findings	Score
	personality disorder.							
McGrath, B. 2012	Exploring registered psychiatric nurses' responses towards service users with a diagnosis of personality disorder.	Ireland	To identify common themes from the analysis of nurses' reported interactions with service users diagnosed with borderline personality disorder and to describe the level of empathy of nurses' towards service users with a diagnosis of borderline personality disorder.	A voluntary sample of 17 out of a possible 31 nurses meeting inclusion criteria and working in an Irish mental health community service were recruited to participate in the study.	Semi-structured interviews constructed using the SPIRS empathy measure (Gallop, Lancee & Garfield, 1990) were recorded and transcribed. A thematic analysis of the interviews was undertaken.	No evidence	Four themes were identified: challenging and difficult; manipulative, destructive and threatening behaviour; preying on vulnerability resulting in splitting off of other service users and boundaries and structure. Overall participants perceived this group as challenging and difficult. The level of empathy expressed by the study participants was level 2 (level 1= no care, level 2 = offer solution, level 3 = affective involvement). This was a lower level than towards other	2

First Author	Title	Country	Research Aims	Sample	Design/Methodology	Reflexivity	Findings	Score
							groups such as schizophrenics and similar to other studies. Further need for training and education identified.	
Nehls, N. 2000	Being a case manager for persons with borderline personality disorder: Perspectives of community mental health center clinicians.	USA	To address the gap in knowledge about case management and how it is practiced and experienced by case managers who care for persons with borderline personality disorder.	N = 17 case managers from a community mental health centre. Hour long interviews with questions and prompts such as, "Tell me about a situation you have experienced as a case manager".	Transcriptions were analysed using interpretive phenomenology with multistage data analysis: identification of meanings or themes, excerpts from the text to support the themes and the reader's interpretation of the themes. Several researchers did this process and then compared themes.	Several researchers reflected on themes.	Themes identified were: monitoring concern about self destructive impulses and monitoring boundaries in terms of the relationship. These were identified as leading to new areas of research, practice and education. There is reference to the focus of containment and limit setting having shifted in non psychoanalytic settings and this needing addressing in case managers practice.	2

First Author	Title	Country	Research Aims	Sample	Design/Methodology	Reflexivity	Findings	Score
O'Connell, B. 2013	Community psychiatric nurses' experiences of caring for clients with borderline personality disorder.	Ireland	To explore the experience of psychiatric nurses who work in the community with people diagnosed with borderline personality disorder.	Purposive sample. N = 15 made up of community nurses caring for patients with borderline personality disorder were approached and ten volunteered for the study.	Semi-structured interview (no detail given). These were transcribed and then analysed by thematic analysis.	No evidence	Three main themes emerged: borderline personality: a mixed bag; positives and challenges and establishing trust and managing risk. Increasing knowledge and structured supervision were seen as key. A conclusion that this group of patients were challenging but could also be rewarding in terms of seeing development even if it is slow.	2
Tillman, 2006	When a patient commits suicide: An empirical study of psychoanalytic clinicians.	USA	To investigate clinicians' experience of patients who commit suicide.	N= 12 purposive sample selected from colleagues for having had the experience of a patient	Phenomenological method using hermeneutic lens of psychoanalytic theory with thematic analysis of transcripts.	Two researchers reflected on themes but there was no evidence of reflexivity on the part of the researchers.	Eight themes: traumatic responses, affective responses, treatment specific relationships, relationships with colleagues, risk management, grandiosity & blame	2

First Author	Title	Country	Research Aims	Sample	Design/Methodology	Reflexivity	Findings	Score
				committing suicide.			and a sense of crisis.	
Treloar, A. 2009	A qualitative investigation of the clinician experience of working with borderline personality disorder.	Australia & New Zealand	To gather comments from clinicians in emergency medicine and mental health settings about their experiences of working with people with borderline personality disorder.	All clinicians were asked to participate and n = 103 (73.57%) agreed.	A demographics questionnaire and an opportunity to provide written comment on their work with people with a diagnosis of borderline personality disorder. A thematic analysis of the written comments.	No evidence.	Four key themes were identified: this group of patients generate an uncomfortable personal response in the clinicians; characteristics of this group contribute to a negative clinician and health service response; inadequacies in the health system in addressing this group of patients' needs and techniques/strategies needed to improve service provision for this group.	2

First Author	Title	Country	Research Aims	Sample	Design/Methodology	Reflexivity	Findings	Score
Wilstrand, C. 2007	Being burdened and balancing boundaries: a qualitative study of nurses' experiences caring for patients who self-harm.	Sweden	To find out what nurses' descriptions are of their experience of caring for psychiatric patients who self-harm.	N = 6 Purposive sample of ward nursing staff.	Narrative interviews focused on two questions: to narrate a satisfying experience of caring for someone who self-harms and to narrate an unsatisfying experience of caring for a patient who self-harms. Analysis of transcriptions was by qualitative content analysis, an interpretive process which focused on subject and context and differences and categories within categories and themes.	Acknowledgment of nurses as researchers and influence on the research.	Two main themes emerged: being burdened with feelings (fearing for the patients' life threatening actions, feeling overwhelmed with frustration, feeling abandoned by co-workers and management) and balancing professional boundaries (maintaining boundaries between self and patient, managing personal feelings, feeling confirmed by co-workers and management, imagining better ways of care).	2
Woollaston, K. 2008	'Destructive Whirlwind': Nurses' perceptions of patients	UK	To explore nurses' perceptions of their relationship	Six participants were interviewed, four were	Semi-structured interviews with open questions covering themes of: attitudes and	No evidence	The core theme was 'destructive whirlwind' as a description of this group of patients.	2

First Author	Title	Country	Research Aims	Sample	Design/Methodology	Reflexivity	Findings	Score
	diagnosed with borderline personality disorder.		s with borderline personality disorder patients.	from an acute ward and two from community services.	perceptions of this group of patients; interaction with these patients; emotional reactions to patients with borderline personality disorder and positive experiences of people with borderline personality disorder. Interviews were transcribed and then analysed using thematic analysis.		Major themes were: care giving; idealised and demonised as the way staff were identified by this group; manipulative and threatening.	

Table 3: A Summary of the Quality Appraisal of the Ten Expert Papers (adapted from CASP 2013)**Key to Value Score: 1 = Strong, 2 = Moderate, 3 = Weak**

First Author & Year	Title	Country	Aims	Method	Sample	Reflexivity	Conclusions	Score
Adshead, 1998	Psychiatric staff as attachment figures: Understanding management problems in psychiatric services in the light of attachment theory.	UK	To demonstrate the relevance of attachment theory to general psychiatric settings.	Description of the theoretical framework of attachment theory and an analysis of therapeutic relationships in the light of this theory.	Use of one case as an example and conclusions from other papers.	Yes, generalised of staff and the institution. No reflexivity on the part of the author.	The value of attachment theory together with psychodynamic approaches to care. Allowing for the recognition of staff and patients' subjectivity and an understanding of the importance of that subjectivity for therapeutic relationships. Attachment theory offers a basis for further research.	2
Evans, 2014	'I'm beyond caring', a response to the Francis Report: the failure of social systems in health care to	UK	Responding to a report that criticised staff for being detached and cruel with an exploration of a management	Theory including Klein and Bion. The history of work on problems of managing	Expert opinion.	Personal opinion throughout.	There is a primitive defensive structure to deal with patient anxieties and blame and anxiety are pushed around the system (referred to as a paranoid schizoid system). Reflective	2

First Author & Year	Title	Country	Aims	Method	Sample	Reflexivity	Conclusions	Score
	adequately support nurses and nursing in the clinical care of their patients.		system that fails to support staff.	anxiety and the impact of the target culture. and budget cuts.			capacity and the capacity to contain are undermined. Clinical and patient voices are not heard. The persecution inherent in the system is antithetical to thoughtful care.	
Evans, 1998	Problems in the management of borderline patients in in-patient settings.	UK	To describe the difficulties of managing borderline patients and how the process of containment gets curtailed.	Description of borderline patients in hospital settings with clinical vignettes.	Two clinical examples from two specialist inpatient units.	Reflection on own role in clinical examples.	Borderline patients evacuate undigested elements of their minds through action. The pressure on staff is to act, rather than think. Ideally the function of the nursing team is to use verbal capacity to reverse the process and turn the action back into words. Containment is a mental task involving the capacity to take in and digest patients' experience. This requires curiosity and doubt.	1
Johnston, 2010	Being disturbed:	UK	Based on the experience of	Blended descriptio	Two reflective	No evidence	Summarises key elements of reflective	2

First Author & Year	Title	Country	Aims	Method	Sample	Reflexivity	Conclusions	Score
	Integration and disintegration in the patient and professional relationship.		running reflective groups in two teams: an inpatient ward and a crisis team. The paper explores reactions to two types of patient: those who are ill and those thought to be illegitimate and morally unacceptable who have a diagnosis of personality disorder.	n of personal experience and psychoanalytic theory.	groups.		practice including: interest in resistance, recognising realistic limits, considering being involved or not despite limits, recognising the importance of limited achievements, placing value on honesty, bearing being disturbed.	
Johnston, 2013	Mirror mirror on the ward: who is the unfairest of them all? Reflections	UK	How to set up and practice reflective group therapy in a variety of mental health	Largely didactic with one vignette.	One reflective group.	No evidence.	Reflective practice is not for staff support but to think about the work with patients. An evaluation referred to by the author makes no link	2

First Author & Year	Title	Country	Aims	Method	Sample	Reflexivity	Conclusions	Score
	on reflective practice groups in acute psychiatric settings.		settings.				between reflective groups and lower levels of stress or burnout.	
Kapur, 2008	Chapter: Applying Bion's concept of psychotic personality to staff and patients.	UK	To apply a Kleinian and post-Kleinian psychoanalytic framework to understanding the management and organisation of mental health services and suggest particular leadership styles that could enhance the work environment and increase the possibility of staff having	Theoretical framework and then single organisational case study.	One residential unit for people with personality disorder.	Yes, for staff and the author.	Structured management, clinical consultation, regular line management and regular weekly reflexive group, teaching, in-service training and support for staff.	1

First Author & Year	Title	Country	Aims	Method	Sample	Reflexivity	Conclusions	Score
			more positive interactions with patients.					
McAllister, 2003	CARE: A framework for mental health practice.	Australia	To problematize caring and explain a new framework for care.	To use a Carl Rogers' theoretical base to devise a new framework for care.	Theoretical with some use of other research.	No evidence	A general CARE framework for mental health staff composed of four elements: containment, awareness, resilience and engagement.	3
Seager, 2006	The concept of 'psychological safety' – a psychoanalytically – informed contribution towards 'safe, sound & supportive' mental health services.	UK	To propose and develop a psychoanalytically informed concept of psychological safety.	Explanation of psychoanalytic theory and then a proposal for a psychoanalytic framework for shaping a protocol in an NHS	No clinical case material.	No reflective practice.	Defines psychological safety and implications for improving provision. Includes the need for containment.	3

First Author & Year	Title	Country	Aims	Method	Sample	Reflexivity	Conclusions	Score
				setting.				
Steinberg, 2013	Integration of psychoanalytic concepts in the formulation and management of hospitalised psychiatric patients.	US	To show how psychoanalytic theory contributed to the understanding and management of a single case and to stimulate thinking about psychoanalytic management.	Description of a composite single case in one consultation.	One composite case.	Yes, for staff attitudes and for the researcher.	Staff reflection (countertransference) is crucial for management and conflict amongst staff is sometimes countertransference. Patients should be engaged in active partnership and adult functioning and verbalisation expression be fostered.	1
Thorndycraft, 2008	The challenge of working with staff groups in the caring professions: The importance of the 'Team Development and Reflective Practice	UK	To highlight the importance of providing reflective groups for staff and particular challenges of working with people diagnosed with borderline	Context and theoretical background, guidance on running groups and descriptions of borderline personalit	Extensive use of one vignette from a reflective group.	Description of facilitator's countertransference headed 'Reflections'.	Guidance on setting up groups.	1

First Author & Year	Title	Country	Aims	Method	Sample	Reflexivity	Conclusions	Score
	Group'.		personality disorder.	y disorder and the consequences for staff with vignettes.				

Table 4: Summary of the Quality Assessment of Three Meta Syntheses Using the Cerqual Tool (2016)**Score: 1 = Strong, 2 = Moderate, 3 = Weak.**

First Author & Year	Method	Relevance	Coherence	Adequacy	Score
Noblett, 2015.	Five databases searched. 38 papers selected. Narrative review of papers analysing: 1) The attitudes held by mental health professionals towards those with mental illness and 2) Stigma and discrimination.	Marginal to this study as focused on all mental health apart from dementia, learning disabilities and developmental disorders making findings specific to personality disorder unidentifiable.	A variety of studies selected for the analysis but no quality assessment tool used.	The general focus on the whole of mental health staff made for some weaknesses in that the focus on 2) was limited to interventions to reduce discrimination in general and their effectiveness. The focus on 1) gave background information relevant to this study.	3
O'Key, 2014.	Social constructionist perspective review of qualitative papers. Criteria given for searches of seven databases. 12 papers identified for review.	Highly relevant to this research as looked at qualitative research in the field of staff attitudes to people with personality disorder.	Quality assessment used was based on one published by the UK National Centre for Social research. Systematic analysis of themes from all 12 papers.	Strong in that searches, exclusions, appraisal and analysis were explained in detail. Themes were clearly identified.	1
Sansone, 2013.	Three databases searched. Specific to responses of	Moderate to this study as focused on patients with	Studies selected without reference to a quality	Lack of search and exclusion details. Useful background in that the conclusion showed a	2

First Year	Author &	Method	Relevance	Coherence	Adequacy	Score
		mental health clinicians to patients with borderline personality disorder. Numbers not given. Analysis of papers by professional grouping ie. nurses.	borderline personality disorder and clinical staff.	appraisal tool. A variety of studies used for the analysis of findings.	majority of participants in various studies harbour negative feelings about people diagnosed with borderline personality disorder.	

Appendix J: The Assessment used as a basis for the interviews

Part A Background

Referral

Shelley was referred by Dr X to the Personality Disorder Service in August 2014. She has a diagnosis of depressive episode (severe) and personality disorders of the borderline, anxious/avoidant and dependent types. On the Thames Valley severity index Shelley had a score of 8. At the time of the assessment Shelley was an inpatient on Y Ward.

Risk

On a risk assessment in September 2014 Shelley was assessed as being medium risk. However, at the time of the assessment it was considered important for her to be accompanied from the ward to the Psychotherapy Department as she was considered high risk. Shelley self-harms by cutting her lower arms deeply near to the artery and acts with suicidal intent by stockpiling pills.

Psychiatric History

Shelley first presented to services in 2012 and since then her condition has deteriorated. She had private psychotherapy for three years which broke down when she started self-harming and acting with suicidal intent. Her psychotherapist told her that she would have to stop working with her and that she would have to go to the NHS for treatment. This left Shelley feeling abandoned. Shelley has a history of experiencing hallucinations, both auditory and visual.

Her first admission as an inpatient was on 9th September 2014 for multiple lacerations to her forearm and suicidal ideas whilst her husband was away at work. Shelley has a history of disordered eating and is currently overweight. When at home Shelley rarely goes out and suffers from agoraphobia.

Medication

At the time of referral this was:

Phenelzine 15 milligrams four times a day

Diazepam 5 milligrams as needed

Quetiapine 200mg a day.

History

Shelley is the second child of parents who are still alive. She has one older brother. She remembers her parents as being unable to listen to her feelings and never hugging her. When taken to school for the first time she was left alone by her mother when all the other children's parents remained with them. Shelley was sexually abused by an unknown man who used to collect her from school and take her to a field and rape her. This continued from when she was eleven for many years.

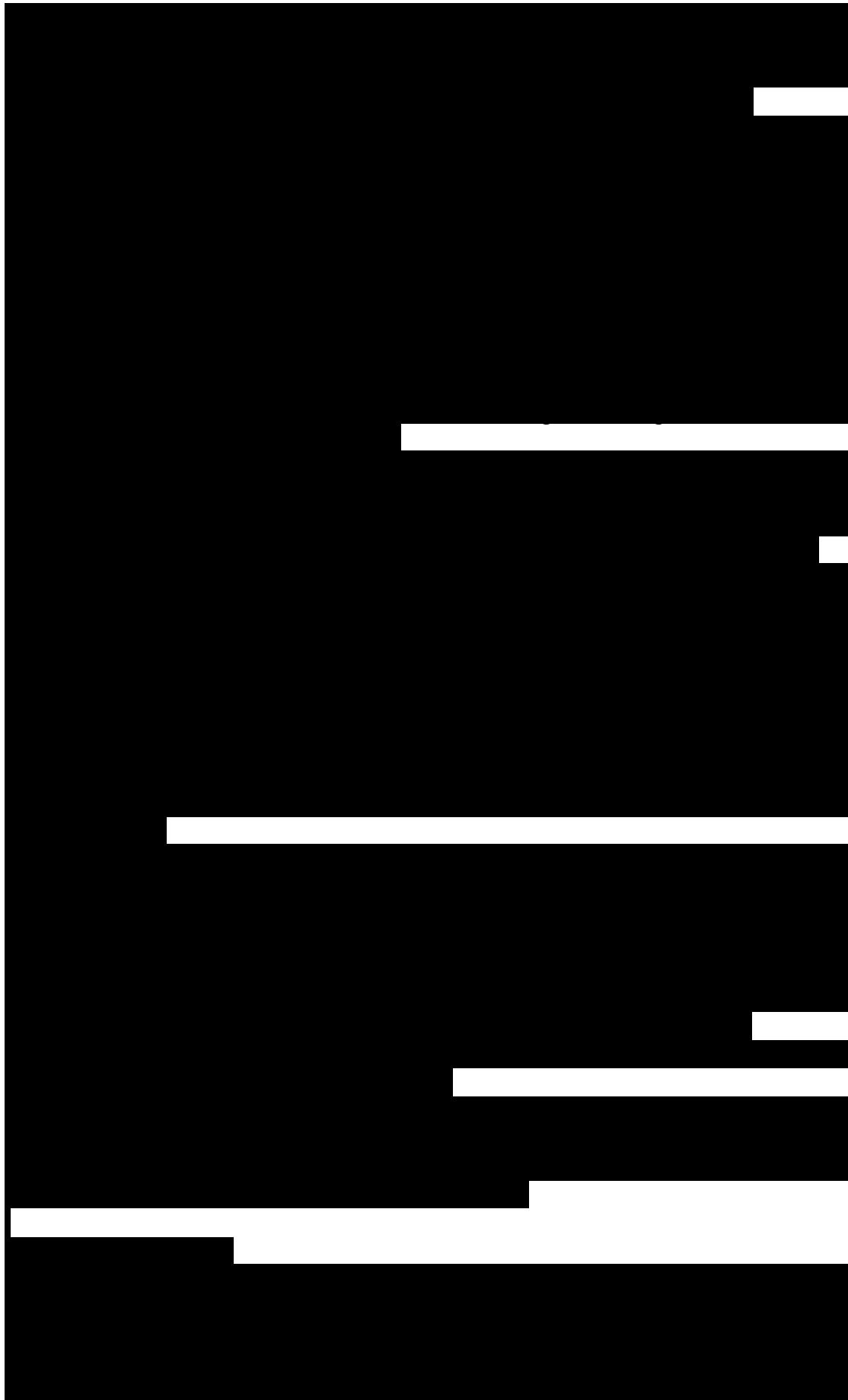
Shelley trained as a [REDACTED] and worked as a head [REDACTED] and then became a lecturer in a [REDACTED] college. Her relationships with some students became very involved and when one of them was killed in a road accident Shelley had a breakdown. She has not worked for three years.

Shelley has been married to her husband, [REDACTED] who works away from home much of the time, for sixteen years. She describes her husband as supportive. They have no children.

Part B Assessment Sessions

[REDACTED]

[REDACTED]





Part C Formulation and Summary

Shelley has broken down relatively recently. Prior to her breakdown she survived by projecting her disturbance and fear of abandonment into others. I think that when the student died it was unbearable as she had to become separate and re-introject her own feelings of abandonment which had previously been projected into someone else. Her level of functioning is very concrete and the realistic quality of the soft place in the box of tissues is evidence of this. Her dreams are also nightmares. Existing as a person in her own right without this level of projection is extremely difficult and terrifying. Her sense of total abandonment is overwhelming and any good object is rendered powerless and excluded. She is at risk of enacting this in terms of her suicidality. She wants to kill the chaos of being on her own, abandoned with unbearable feelings and at the same time excludes others from helping her by hiding pills.

In the assessment sessions it was notable how any good experiences turned bad. For instance, the good experience of baking in the kitchen with her mother as a child had turned into visions of terrifying gingerbread men in the trees. There is a traumatic loss which will have to be worked with and articulated and this will be difficult, but I think possible, therapeutic work. The fact that Shelley did manage for so long in the past and has a good relationship with her husband now will be helpful.

In talking about her admission to Iris with the team it was recommended that further preparatory meetings were held with Shelley and her recovery coordinator, and possibly her husband, during the waiting period.

Appendix K: The Information Sheets



1. Information Sheet for Service Users

Study Title: A Study of Staff Responses to Service Users

Invitation and brief summary

The study aims to find out about the responses of staff in Devon Partnership Trust to service users involved with the personality disorder service. Finding out about these responses will help us to improve our services.

The purpose of this information sheet is to invite you to give permission for the anonymised record of your assessment to be used in this study.

What's involved in the research?

This research aims to explore how staff respond to service users, to find out about particular kinds of response and to consider whether these responses can be improved throughout the organization.

The record of your assessment, written by a psychotherapist, would be used as the basis of interviews with staff working in or connected with the personality disorder service. The staff will all be employees of Devon Partnership NHS Trust.

The record of the assessment will be anonymous and any identifying references to you personally or to others will be removed before the record is used for the interviews.

Twenty staff will be interviewed for this study from various levels of the organization. No comments from these interviews will be attributed to individuals in the final report.

How would this affect you?

Your assessment record is part of the normal record of your admission to the personality disorder service. It would normally be held in a computer folder called a secure envelope as explained in the leaflet, "How private is my Psychotherapy?" published by Devon Partnership NHS Trust.

In the case of the record being used for this study the anonymised record would be printed out and given to staff to read as part of the interview process. The print out will be destroyed immediately after the interview.

What are the possible benefits of taking part?

- You would be contributing to the development of improved care for yourself and others
- Personality disorder would be given a high level of consideration by the staff involved in the research study

What are the possible disadvantages and risks of taking part?

- Twenty staff will know details of your case although you will not be personally identified in the report

Further supporting information

- Any personal details, including your name, age and address together with any personal details of others will be removed from the record of your assessment.
- The anonymised record will be printed out for the purpose of the interviews and then destroyed.
- The researcher will hold a copy of the anonymised record on an encrypted personal computer. This record will be destroyed after the end of the study.
- You are free to withdraw from the study at any time
- The research is being carried out as part of a doctoral programme at the University of Exeter in collaboration with Devon Partnership Trust
- The proposal has been reviewed and approved by the University of Exeter and Devon Partnership NHS Trust Research and Development Department and Ethics Committee
- You can discuss this information sheet further by contacting the researcher: Elizabeth Weightman, Psychotherapy Department, Wonford House, Dryden Road, Exeter EX2 5AF Tel: 01392 208714/5 Email: elizabeth.weightman@nhs.net

or for independent advice: PALS Team, Devon Partnership Trust, Wonford House Hospital, Dryden Road, Exeter EX2 5AF Tel: 0800 0730741 Email: dpn-tr.pals@nhs.net



2. Information Sheet for Staff

Study Title: A Study of Staff Responses to Service Users

Invitation and brief summary

This study aims to find out about the responses of staff in Devon Partnership Trust to service users referred to the personality disorder service. Finding out about these responses will help to develop the services offered.

The purpose of this information sheet is to invite you to participate in the study by giving your views about a case.

What's involved in the research?

This research aims to explore how staff respond to the details of a particular case.

The method of the research involves exploring these issues by gathering responses, via interviews, to an anonymised written assessment of a service user who has been diagnosed with personality disorder.

The interview involves reading an assessment and then taking some time (maximum fifty minutes) to record whatever comes into your mind in response to the material. This recording would take place in the presence of the researcher (myself) and will be held at Wonford House at a time to suit your convenience. There will be time for a de-brief discussion afterwards.

Twenty staff from various levels of Devon Partnership Trust will be interviewed for this study. No comments from these interviews will be attributed to individuals in the analysis or final report.

How would this affect you?

The interview involves you knowing details of a case. Some of the content may be disturbing. Time will be allowed to talk any disturbance through following the interview.

The material from the interviews will be used anonymously and no comments will be attributed to individuals. Transcriptions will be stored anonymously and on a secure encrypted drive and will be destroyed after the research is completed.

What are the possible benefits of taking part?

- Your views would be listened to
- You would be contributing to developing services for people with personality disorder

- You would be influencing a report which could enhance reflective practice and supervision for staff
- You would have the opportunity to reflect on the details of a case
- You would have the opportunity to talk through your responses with the researcher

What are the possible disadvantages and risks of taking part?

- You need to allocate one hour of your time
- You may be concerned that, although anonymised, your comments will be identifiable

Further supporting information

- Any personal details together with any personal details of others mentioned will be removed from the record of the interview.
- The researcher will hold a copy of the anonymised record of the interview on an encrypted personal computer. This record will be destroyed after the end of the study.
- You may withdraw from the study at any time
- Declining to participate or withdrawing from the study without giving a reason will have no detrimental effect whatsoever on your employment
- The research is being carried out as part of a doctoral programme at the University of Exeter in collaboration with Devon Partnership Trust
- The proposal has been reviewed and approved by the University of Exeter and Devon Partnership NHS Trust Research and Development Department and Ethics Committee
- You can discuss this information sheet further by contacting the researcher:

Elizabeth Weightman, Psychotherapy Department, Wonford House, Dryden Road, Exeter EX2 5AF Tel: 01392 208714/5

Email: elizabeth.weightman@nhs.net

or for independent advice:

Tobit Emmens, Research and Development Department, Wonford House Hospital.

Email: tobit.emmens@nhs.net

Tel: 01392 674114

Appendix L: Consent Forms
1. Service User Consent Form

[YOUR LETTERHEAD HERE]

Centre Number:

Study Number:

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: A study of staff responses to service users

Name of Researcher: Elizabeth Weightman

Please initial all
boxes

1. I confirm that I have read and understand the information sheet dated 28th June 2014 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐
3. I understand that the anonymised record of my assessment may be looked at by individuals from Devon Partnership NHS Trust and the University of Exeter, where it is relevant to taking part in this research. I give permission for these individuals to have access to this record only.

☐
4. I agree to take part in the above study.

☐

Name of Participant

Date

Signature

Name of Person
taking consent.

Date

Signature

2. Staff Consent Form

[YOUR LETTERHEAD HERE]

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: A study of staff responses to service users

Name of Researcher: **Elizabeth Weightman**

Please initial all
boxes

5. I confirm that I have read and understand the information sheet dated **28th June 2014** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
6. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected ☐
7. I understand that declining to participate or withdrawing from the study without giving any reason will have no detrimental effect on my employment. ☐
8. I understand that the anonymised record of my interview may be studied by individuals from Devon Partnership NHS Trust and the University of Exeter, where it is relevant to taking part in this research. I give permission for these individuals to have access to this record only. ☐
9. I understand that an audio recording of the interview will be made and used in an anonymised form for purposes of the research only. ☐
10. I agree to take part in the above study. ☐

Name of Participant

Date

Signature

Name of Person
taking consent.

Date

Signature

Appendix M: Interview Schedule

Interview Schedule

The first statement below is to be said prior to the maximum time of 10 minutes allocated for reading the assessment.

Interviewer:

As you will have seen from the invitation letter I am going to give you a written psychoanalytic assessment of an anonymous service user to read. You can take up to ten minutes to do this but if you feel ready to start talking about your reactions before this we can start before the ten minutes are up.

10 minutes reading time.

Switch on recorder.

Interviewer:

We have 50 minutes for this part of the interview but if you wish to end before xx (actual end time) please feel free to say so.

Now the invitation is to talk about whatever comes into your mind. I will only intervene with comments that are clarifications, additional comments to encourage a further exploration of meaning or comments on feelings evoked during the interview. *

At the end of the interview.

Interviewer:

Thank you.

Switch off recording.

Interviewer:

If you would like to talk through this process I can do this now or at another time, as you wish.

Appendix N: Ethical Approvals

1. University of Exeter Ethical Approval

To: Elizabeth weightman

Reply-To: D.M.Salway@exeter.ac.uk

Your application for ethical approval (2014/632) has been accepted

2. NHS Ethical Approval

***Health Research Authority***

11 July 2014

Ms Elizabeth Weightman 146 Heavitree Road Exeter EX1
2LZ

Dear Ms Weightman

Study title:

REC reference: IRAS project ID:

An investigation into the psychoanalytic containment
provided by staff in an institution in relation to a service
user with a diagnosis of personality disorder 14/SW/1001

155393

NRES Committee South West - Cornwall & Plymouth

Level 3 Block B Whitefriars Lewins Mead Bristol BS1 2NT

Telephone: 01173421390 Fax:01173420445

Thank you for your letter of 9th July 2014, responding to the
Committee's request for further information on the above
research and submitting revised documentation.

The further information has been considered on behalf of the
Committee by the Chair.

We plan to publish your research summary wording for the
above study on the HRA website, together with your contact

details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Kirsten Peck, nrescommittee.southwest-cornwall-plymouth@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the

A Research Ethics Committee established by the Health Research Authority

study.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential

participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

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Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document		
	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University of Exeter Prof. Indemnity]		16 August 2013

Interview schedules or topic guides for participants [Interview Schedule]	1	14 March 2014
IRAS Checklist XML [Checklist_21052014]		21 May 2014
IRAS Checklist XML [Checklist_01072014]		01 July 2014
Letter from sponsor [Exeter university Sponsorship Letter]		06 May 2014
Other [Certificate of Attendance - Research Governance Training]		02 July 2013
Other [Exeter University Public Liability Insurance]		19 July 2013
Other [2nd Supervisor CV]		16 May 2014
Participant consent form [consent Form - Service User]	1	19 May 2014
Participant consent form [Consent Form - Staff]	2	28 June 2014
Participant information sheet (PIS) [Information Sheet for Staff]	2	28 June 2014
Participant information sheet (PIS) [Information Sheet Service User]	2	28 June 2014
REC Application Form [REC_Form_21052014]		21 May 2014
Referee's report or other scientific critique report [University Pass Report]		14 March 2014
Research protocol or project proposal [Major Research Proposal]	1	14 March 2014

Summary CV for Chief Investigator (CI) [CV Chief Investigator]	1	16 May 2014
Summary CV for supervisor (student research) [Supervisor 1 CV]	1	16 May 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements A Research Ethics Committee established by the Health Research Authority

The attached document “*After ethical review – guidance for researchers*” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- . Notifying substantial amendments
- . Adding new sites and investigators
- . Notification of serious breaches of the protocol
- . Progress and safety reports

Notifying the end of the study The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures. Feedback You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/> We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/> With the Committee's best wishes for the success of this project. Yours sincerely Canon Ian Ainsworth-Smith Chair Email: nrescommittee.southwest-cornwall-plymouth@nhs.net Enclosures: "After ethical review – guidance for researchers" [SL-AR2] Copy to: Gail Seymour Mr Tobit Emmens, Devon Partnership Trust A Research Ethics Committee established by the Health Research Authority

Appendix O: Example Email to Participants

Dear x

I hope that you are well.

I am emailing to ask if you would consider being an interviewee for my DClin research. It would mean taking an hour of your time to do the interview with me in Exeter at the Psychology Department. Would this be possible?

I have attached a briefing sheet and really the interview will be an opportunity for you to free associate to an assessment that I have written, there won't be lots of questions!

I would be very grateful if you would think about doing this and then we can arrange a mutually convenient time.

With my best wishes
Elizabeth

Appendix P: Seven Step Approach to Discursive Analysis

Seven Steps in Discursive Psychology Research

Adapted From Wiggins and Potter (2008)

Step Description

- . 1 **Devising a research question.** Guided by an interest in a particular form of interaction.
- . 2 **Gaining access and consent.** Ethical and practical considerations for accessing the data.
- . 3 **Data collection and building a corpus.** DP requires a thorough examination of a collection of similar instance.
- . 4 **Transcription.** Features of talk that are relevant are represented (emphasis, overlap, pauses, intonation etc.).
- . 5 **Coding.** Iterative process of sifting through the data for instances of a phenomenon. Issues may emerge or disappear at this point.
- . 6 **Analysis.** Focus on how discourse is constructed, constructive of different versions of events, situated in interaction, and bound up with actions.
- . 7 **Application.** Analysis and findings are linked to the context under study.

Wiggins & Potter, 2008, p. 80-86.

Appendix Q: Example Excerpt from Interview (First page only)**131011_0024**Key:**I: Interviewer****R: Respondent**

R: So the first thing about the oral history offered is my sense of its incompleteness. So I'm always interested in what's not presented, umm, as well as what is presented. So, for example, I'm... I'm not clear whether there's any forensic history, or history of offending behaviour, umm, I'm not sure what her relationship with drug and alcohol might be. Umm, I don't have a keen sense from the re-representation that much thought had been given to her pre-morbid personality, and, err, my sense would be that by the Maudsley standard of, err, clerking in and presenting a patient, quite a lot of the information was missing. I think the second thing is anybody with this level of complexity, it's incredibly helpful to have a commentary about informant information from friends and family and carers and other supporters who can, err, shed some light as to whether the narrative is consistent and whether it's valid with other...

Other points of reference, and whether the experiences are, umm, held in common, or whether there's a difference of view about things. Umm, and similarly my sense is that it can be incredibly helpful to have a summary of the general practice record, because somebody like this, who's presenting with a history of no periods and overweightedness since young life might very well have a condition like polycystic ovarian disease, or some other endocrine disorder which could be part of the root cause of her belief system, and also her depression. So I can't compute, based on the information presented, well enough to understand whether... what the organic risk potential might be. Umm, I hear enough in the story to suggest that there's a disorder of attachment, that a number of the things that may have happened to her might have further disordered her experience of relationships, but, again, a clarity in the referral around, so what really went on for her in the first year of life?

What was infancy like? Were the normal milestones achieved? When did she first start to form peer relationships? How did they go? Why would she ultimately end up in a position of vulnerability which led to the events that have secondarily traumatised her? So all of that puzzles me, I was... I am very concerned about the inadequacy of risk assessment and explanation, which has, in my view, become an industry at the expense of decent formulation. So I would be interested in a robust bio-psychosocial formulation that looked at the predisposing factors, the biological ones, which we've discussed, the psychological factors, in terms of her cognitive behaviour, emotional development that might have lead her to vulnerability, and also the social factors that potentially put her at risk. And then I'd look at the precipitance. Was it some change in her biology that led her into this risk?

Or was it her emotional, behavioural, or cognitive reaction to the encounters that led her into this risk, with PTSD type phenomena, etc? And then finally the social position, you know, the vulnerability, the... the school setting, the,

erm, access to people who would abuse a vulnerable person. What was that about? And then, thinking through... I'd prefer the referring team to be thinking through, 'So what are the maintaining factors here? What are modifiable?

Appendix R: Excerpt of Coding Matrix Report (Reflection and Containment Implied) First two pages.

Reference 1 - 0.58% Coverage

I think she needs to talk. I really do think she needs to talk and talk and talk until she is talked out.

Reference 2 - 3.80% Coverage

I mean, the older you are, you look back, and people didn't do touchy-feely then. You kept your stiff upper lip, and 'I don't want to talk about it,' and it was all about brushing it under the carpet. And if it we don't talk about it, it doesn't exist. Er, now, of course, we've gone to the other extreme. [Coughs] Everybody wants to tell everybody everything about the most intimate things. But she... It's, it's interesting, because I would really like to know what, sort of, age/era she's in, you know. But obviously, you can't. So it, it's... Perhaps it's just to do with that as well, that she can't open up and her parents can't ask because they are stuck in this, sort of, time warp there. I don't know.

<Internals\\Int10> - § 6 references coded [20.85% Coverage]

Reference 1 - 6.76% Coverage

So it's clear that undertaking therapeutic work with people with this level of difficulty is both very disturbing for the people working with it and very disturbing for her, and isn't an undertaking to be, er... isn't to be undertaken lightly, um, or without very careful thought. However, it seems to me that the alternative of, um, er, treatment... of, of not addressing the emotional difficulty and, um, er, and, and simply failing to recognise the problem, and, er, treating it almost in the same way, as though it was a psychotic disorder with medication and admission, doesn't seem to me to be a reasonable solution for a group of patients who are so troubled, and, er, where really very often, the possibility of therapeutic work under the right circumstances hasn't, hasn't even been tried. And if one considers that about a third of the patients presenting to the mental health service fall into this group, this seems to me to be an enormous unresolved and under-researched problem in mental health services. And, er, so I'm both very interested in it and very keen that we should do our best to try and do something about it, at least to find out the limitations of what can be done or, where it's clear that somebody is beyond the point that they can use therapeutic work, what can be done to support them to have the best quality of life that they can manage. Um, or at least that the people who are working with them should have a reasonable understanding of what the problem is and so be able to talk to them in a way that demonstrates some understanding of the difficulty to the patient. Because it seems that without, to me, that without that, these states of mind are, kind of, unendurable, really. So, um, er.. So that, that's the reason for my being interested in it.

Reference 2 - 4.19% Coverage

how concretely she expresses her feelings, so, I guess, that, er, she does want to take flight inside something in the face of something very anxiety provoking in the external world, doesn't she? And, um, er, and, and that she does that very literally in relation to the inside of her body when she cuts herself very deeply, trying to find her, her, her way to some sort of soft inner place where she can take refuge but also in her finding her way into the ward, um, where she's

been for some time and can't be discharged. And those things seem to me absolutely tied up with one another. And, um, er, and her agoraphobia and terror of going outside, um, er, probably, er, is another manifestation of the same thing in her home life. Um, but having met this lady myself, er, [pause] we talked about the, there being a conflict between the man's voice in her head and her taking flight into this place inside her body, but in doing so her ending up doing something to herself what was rather like what he'd done to him that, to, to her, the attack on her body that happens when she, when she cuts herself -

Reference 3 - 2.46% Coverage

I suppose I think that one has to start with the patient where they are at the point that they come to you. And if they are at the point that they can't want anything, then one has to try and find a way of engaging with them at that point where they don't want anything. And, er, and there's a reason that they don't want anything. So as Ron Britton talks about it - 'The most difficult problem for all of us to negotiate is the feeling of I want you where I and you and are separate and there's a want in between. So there's the need for the object without being in control of the object and, and recognising that you are separate from the object'.

Reference 4 - 4.81% Coverage

I think mostly, even the most suicidal, hopeless, at the far end of despair patient who only wants to be dead is in that state trying to communicate something and they need another person to participate with in this dance, which is why they, um, er, which is why they engage with the mental health services and why they, er, tell people of their suicide plans. It's not that they don't intend to carry it through. It's not that they are manipulating people. It's that, er, it's that for very severely disturbed narcissistic patients they simply cannot manage their own states of mind in one mind. They need two. So they either need another person's mind to acquire as their own or they need a place to attribute the past themselves that they can't own. So they either have to make two people one person or they have to divide their one person into two, one, one way or the other. So they are always looking for another person to participate in this way of managing themselves. And so really I, sort of, see it as my job to, to pick up the other end of the piece of string that the patient has. And there is always another end of the piece of string, it doesn't matter how, er, er, hopeless the situation seems. And the, and the patient is looking for somebody to do it.

Reference 5 - 1.61% Coverage

to grasp the complexities of this particular patient group requires a very sophisticated understanding of the problem and most people just aren't trained to even see it, to even recognise it. They are trained to work with particular clusters of symptoms and to do things that address those symptoms. And they... it, it just doesn't stand a single snowball's chance of getting to grips with this kind of, of level of problem.

Reference 6 - 1.03% Coverage

And support, because actually starting to think of it as an emotional issue means that you have to engage with it emotionally. And that's very difficult. It can't happen without a proper container for the staff, proper support and supervision and thinking for the staff.

Reference 1 - 3.45% Coverage

One of her experiences with that engagement was going back to sleep, and, erm, whether, you know... it's difficult to comment on each situation, but what you'd... what I'd want to see, if I was working on a ward, or a manager of a ward, is that when people express, you know... they wake up quite distressed, erm, you know, my experience

Appendix S: Shelley's Statement

(typed copy of handwritten statement with punctuation and style as written by Shelley with all names changed)

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]